

5315

24320 NOV 18 1985
S.R.

TO MEDICAL EXAMINEE: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1 RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF INFECTIOUS DISEASES RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF MIAI RECORDS 201 W. PRESTON ST. BALTIMORE, MD. 21201

DECEDENT'S NAME (TYPE OR PRINT)		FIRST MIDDLE		LAST		DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2d HOUR 9 AM			
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	8c. DATE REC'D. BY REGISTRAR	9c. DATE REC'D. BY REGISTRAR	10c. DATE REC'D. BY REGISTRAR	11c. DATE REC'D. BY REGISTRAR			
male	white	June 8, 1922	64 yrs.	MONTHS	DAYS	MONTH	DAY	YEAR	MONTH	DAY	YEAR		
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA						Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hospital				truck driver		trucking					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21740					
Maryland	Washington	Hagerstown				30 Beckley Road							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Carther		Anna R. Jenkins											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
yes U.S. Army		223 14 0731		Hazel L. Aleshire, Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest 427</u>													
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic disease (cardiovascular) 429</u> } DUE TO, OR AS A CONSEQUENCE OF (c)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Emphysema, previous stroke, hypertension</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. <u>Dr. Aleshire</u>		MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED <u>11/10/86</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
burial		Nov. 14, 1986		Cedar Lawn Mem. Park		Hagerstown, Washington, Md.							
24 FUNERAL DIRECTOR NAME		MINNICH FUNERAL HOME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
415 E. Wilson Blvd., Hagerstown, Md. 21740				NOV 14 1986		Julia Minnich Landae							

SI 320 10112

Smooth

Smooth

SEA Xerophytic
Subtropical Scrub

Subtropical Scrub

Subtropical Scrub

Subtropical Scrub

Subtropical Scrub

Subtropical Scrub

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove from this certificate and retain with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 33138			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Susan			V	ANTHONY		November	19	1986	4:15 AM				
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS				
Female	Caucasian	MONTH	DAY	YEAR	88	MONTHS	DAYS		HOURS	MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			10a USUAL OCCUPATION			10b KIND OF BUSINESS OR INDUSTRY		
W. VA.	USA				Washington County MD.			Housewife					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b STREET ADDRESS / ZIP CODE				
Hagerstown			Avalon Manor			13a STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE			
MD			Washington MD			MD			7E. Washington St. Alexander House				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS					
Charles				Flynn	Ida			Hagerstown, Md.			Ward		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			579-10-5272			Catherine Davis			minutes				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												Years	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arthritis Depression - Anxiety Old CVA's Auto Stenosis</i>													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
19b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
21g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21h. LOCATION CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>8-5-</i> , 19 <i>86</i> , to <i>11-19-</i> , 19 <i>86</i> , that (II) (we) last saw the deceased alive on <i>11-19-86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>W. Dush. MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11-20-86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. Dush. MD</i>			22e. ADDRESS <i>411 Division Ave. Hgst Md</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Nov. 21, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Md. National Mem. Pk.			23d. LOCATION Laurel Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS Minnich Funeral Home 415 East Wilson Blvd.			25a. DATE REC'D. BY REGISTRAR NOV 24 1986			25b. REGISTRAR'S SIGNATURE <i>See Death Certificate</i>				
D�MH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, medical specimens should be marked or otherwise identified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 863315

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Ralph</i>			<i>Edwin</i>	<i>Barkdoll Sr.</i>		<i>11</i>	<i>03</i>	<i>86</i>	<i>7:25 A.M.</i>		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
<i>Male</i>	<i>White</i>	<i>08 09 1909</i>			<i>77</i> YRS						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Maryland</i>	<i>U.S.A.</i>			<i>Washington</i>							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Hagerstown</i>	<i>Washington County Hospital</i>			<i>Foundry Worker</i>			<i>Frick Co.</i>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. STREET ADDRESS / ZIP CODE								
<i>Maryland</i>	<i>Frederick</i>	<i>Myersville</i>	<i>11815 Wildcat Rd/21773</i>								
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST				
<i>George</i>			<i>Barkdoll</i>	<i>Delia</i>			<i>Marken</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>	<i>193-12-9968</i>			<i>Frances Barkdoll</i>	<i>11815 Wildcat Road</i>			<i>Myersville, MD 21773</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))						<i>RESPIRATORY ARREST</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>RESPIRATORY ACIDOSIS, HEART FAILURE</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.						DUE TO, OR AS A CONSEQUENCE OF (c) <i>OBSTRUCTIVE ARTERIOSCLEROTIC HEART DISEASE</i>					
DUE TO, OR AS A CONSEQUENCE OF (d) <i>OBSTRUCTIVE PULMONARY DISEASE</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (the hospital) attended the deceased from <i>Aug 11th</i> , 19 <i>76</i> to <i>Nov. 3rd</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>NOV 1st</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>M. Lardizabal</i> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>11-3-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. P. LARDIZABAL M.D.</i>						22e. ADDRESS <i>382 S. Cleveland, HAGERSTOWN, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>11-4-86</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Smithsburg Crematorium</i>			23d. LOCATION CITY OR TOWN <i>Smithsburg</i>	COUNTY <i>Washington</i>	STATE <i>MD</i>				
24. FUNERAL DIRECTOR <i>Tina L. Ricketts</i>	ADDRESS <i>Ricketts Funeral Home Myersville, MD</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 10 1986</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Darden-Landau</i>						

059210 100 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21a marked item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 3 3 1 4 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Sophie	MIDDLE —	LAST Bartell	2a. DATE OF DEATH MONTH NOVEMBER	DAY 11	YEAR 1986	2b. HOUR 11:15 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH NOVEMBER		DAY 13	YEAR 1900	6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS YRS
7a. BIRTHPLACE COUNTRY Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington			IF UNDER 24 HRS HOURS MIN.
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor		12b. KIND OF BUSINESS OR INDUSTRY Men's Clothing	
13a. STATE MD.	13b. COUNTY MONT.	13c. CITY OR TOWN GAITHERSBURG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8501 PLUM CREEK DR. 20879		
14. FATHER'S NAME UNKNOWN	MIDDLE	RUBASHEOSKY	15. MOTHER'S MAIDEN NAME UNKNOWN		MIDDLE	TEKLA LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 219-20-7893A	17. INFORMANT Joseph A. Bartell		ADDRESS Same as # 13		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congenital esophageal hernia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Some organic brain syndrome</i> <i>Sudden</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased at _____, 19_____, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. L. KUGLER, M.D.</i>	22c. DEGREE <i>Resident</i>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED <i>11/3/86</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. KUGLER, M.D.	22f. ADDRESS KEEDYSVILLE, MD 21756						
23a. BURIAL, CREMATION, REMOVAL ISPECIALLY BURIAL	23b. DATE NOV. 5, 1986	23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL CEM.	23d. LOCATION BALTIMORE	BALTIMORE	MD	VATE	
24. FUNERAL DIRECTOR FRANCIS H. BARBER	LAYTONSVILLE, MD. 20879	25a. DATE REC'D. BY REGISTRAR NOV 6 1986	25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Landess</i>				

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DRAFT

2010-12-12

RECORDED BY: [unclear]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1 - FOR STATE REGISTRAR											REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
JACK			HANSON		Beachley	11 8 86					86	945 AM
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White		MONTH 5 DAY 28 YEAR 03			83 YRS			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MD			USA					Washington County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN			WASH. Co. Hospital			Retired Physician			Medical			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MD			WASH		Hagerstown					163 S. Prospect St. 21740		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			
			Harry	Knode	Beachley	Alice			Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			212-38-9299			Louise Beachley same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Prostate cancer with metastasis</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>86</u> , to <u>11-8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Ali Rose</i>			22c. DEGREE <i>Dug</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>Burial</u> <u>11-11-86</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Rose Hill Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Hagerstown</u> COUNTY <u>Wash. Md.</u> STATE			
24. FUNERAL DIRECTOR NAME			305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Gerald N. Minnich			Hagerstown, Maryland			NOV 13 1986			<i>Gerald N. Minnich</i>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper and send with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 shows any injury, or other traumatic event, it must be noted on page 3 and 2 should be filed within 24 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
FOR STATE REGISTRAR			20 DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST Helen	MIDDLE Mae	LAST Bear	5. DATE OF BIRTH MONTH 3			DAY 24	YEAR 1911	6. AGE (IN YEARS LAST BIRTHDAY)	75	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.			
3. SEX Female			4. RACE White			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD								
7a. BIRTHPLACE COUNTRY Rohrersville, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			10. CITY OR TOWN OF DEATH Boonsboro			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home			12a. USUAL OCCUPATION Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13c. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 16 Chestnut Ave. 21713					
14. FATHER'S NAME FIRST Harry			MIDDLE W.	LAST Eakle	15. MOTHER'S MAIDEN NAME Della												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No 217-74-6154			17. INFORMANT Mrs. Angeline L. Buckheit, Baltimore, Md.			ADDRESS 1919 Calais Court			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Aspiration for asphyxiation			DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent gastric reflux			1 hour								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(c) Parkinson's disease, Severe.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Pharyngitis, pneumonia																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.																	
22b. SIGNATURE <i>R.L. Kugler</i>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED NOV 17 1986								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.L. Kugler</i>			22e. ADDRESS Geeting Lane, Kodysville, Md 21756														
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 11-13-86			23c. NAME OF CEMETERY OR CREMATORIUM Locust Grove Cemetery			23d. LOCATION CITY OR TOWN Locust Grove, Wash. Co., Md.								
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.			ADDRESS Boonsboro, Md. 21713			25a. DATE REC'D. BY REGISTRAR NOV 17 1986			25b. REGISTRAR'S SIGNATURE								
DMMH - 16 60M 7/B4 (VRA 15, 4)																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual occurrence, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 025724 DEC-300											33143		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR					2d. HOUR 3:05 A.M.		
MARY PEARL BECKLEY						November 24, 1986							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		White		Oct. 13, 1905			81						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Washington County Hospital		Housewife									
13a. STATE Maryland						13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route #2, Box 331 21740	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
George			Harsh	Mary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		213-42-2191		Seth K. Schnebly			Route #1 Clearsprings, Md.		12-13 DAYS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION AND CONGESTIVE HEART FAILURE AND													
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (X) attended the deceased from Nov. 13, 1986, to Nov. 24, 1986, that (I) (X) lost saw the deceased alive on Nov. 23, 1986, and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above. (I) (X) did not (X) view the body after death.													
22b. SIGNATURE Edward W. Ditto, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Nov. 25, 1986							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.		22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Nov. 26, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Salem Reformed Cemetery		23d. LOCATION CITY OR TOWN Hagerstown		23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd. Hagerstown, Maryland 21740		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 01 1986		25b. REGISTRAR'S SIGNATURE Julia Sanders-Radaea							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 30 33141					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>James F</i>					<i>Bowers</i>	<i>11 30 86</i>					<i>86</i>	<i>4 P M</i>			
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
<i>Male</i>			<i>White</i>	<i>09 04 1904</i>			<i>82 yrs</i>								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
<i>Clear Spring,</i>			<i>USA</i>						<i>Washington</i>						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>Hagerstown</i>			<i>Wesley Long Hospital</i>			<i>retired from Victor Prod.</i>									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS ZIP CODE	
13a. STATE <i>West Maryland</i>										13c. CITY OR TOWN <i>Hagerstown</i>				<i>Penngrove Avenue 21748</i>	
14. FATHER'S NAME FIRST MIDDLE			15. MOTHER'S MAIDEN NAME Mary FIRST Mills MIDDLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <i>219-05-2330</i>			17. INFORMANT <i>Mrs. Lena Bowers</i>			
						<input type="checkbox"/>						ADDRESS <i>Rt. 1 Box 64 Big Spring, MD.</i>			
18. CAUSE OF DEATH (Enter only one cause per line on (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										<i>Cardiac pulmonary arrest</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular accident</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <i>Cardiac arrhythmia -</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Chronic obstructive lung disease</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>11/21/86</i>			CITY OR TOWN <i>11/26</i>			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/26</i> , 19 <i>86</i> , to <i>11/26</i> , 19 <i>86</i> , that (I) (we) lost sow the deceased alive on <i>11/26</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Francisco L. Andrade</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <i>363 S. CLEVELAND AVE - HAGERSTOWN MD</i>			22f. DATE SIGNED <i>12/1/86</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>12-03-86</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Shanktown Cem.</i>			23d. LOCATION CITY OR TOWN <i>Big Pool, Wash. MD.</i>			23e. STATE			
24. FUNERAL DIRECTOR <i>DONALD E. THOMPSON FUNERAL HOME INC.</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 5 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Deidra Andrade</i>									
(VRA 15, 4)															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or medical examiner's office.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other trauma

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 5314					
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Mildred</i>	MIDDLE <i>A.</i>	LAST <i>BOWERS</i>	2a. DATE OF DEATH			MONTH <i>11</i>	DAY <i>30</i>	YEAR <i>86</i>	2b. HOUR <i>11 35 AM</i>			
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR <i>May 16, 1912</i>			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Potomac Towers 21740			
14. FATHER'S NAME FIRST Harry			MIDDLE R.			LAST Miller			15. MOTHER'S MAIDEN NAME FIRST Bertha			MIDDLE V.		LAST Moon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Paul Bowers			ADDRESS George M. Bowers, Hagerstown, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										<i>cardiac arrest</i>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										<i>Congestive heart failure</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>11/30/86</i>					
22b. SIGNATURE <i>Q. Waheed</i>										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABDUL WAHEED</i>										22e. ADDRESS <i>1610- Oak Hill Ave. Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Dec. 2, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Shanktown Cemetery			23d. LOCATION CITY OR TOWN Big Pool, Wash., Maryland			STATE			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740										25a. DATE REC'D. BY REGISTRAR <i>DEC 5 1986</i>	25b. REGISTRAR'S SIGNATURE <i>1.ia. David Landes</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's office should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 86 33140												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
<i>Charles S. Samuel Bowman</i>						11 7 86			11 25 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		White		4 1 08			78 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD		
Maryland		U.S.A.					Washington					
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hospital		foreman			railroad					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Carroll		Union Bridge				24 S. Main St./21791				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
John		Pearl								Minnick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No none			705-10-6017			Helen B. Bowman			Union Bridge, MD			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>gas gangrene, right leg stump</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>35 minutes</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION <i>11/5/86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ischemia, gangrene Right leg</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>8/10/86</i> to <i>11/7/86</i> , that (I) (we) last saw the deceased alive on <i>11/2</i> , <i>1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Stephen M. Sachs, MD</i>		DEGREE						22c. DATE SIGNED <i>11/7/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEPHEN M. SACHS</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/8/86		23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN			COUNTY STATE		
24. FUNERAL DIRECTOR NAME D. D. Hartzler		ADDRESS Union Bridge, MD					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>NOV 10 1986</i>		

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3314

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- STATE REGISTRAR			REG. NO.								
1. DECLARED NAME (TYPE OR PRINT)			FIRST Louis			MIDDLE L			LAST BRAMEL		
1. SEX M		4 RACE W		5. DATE OF BIRTH MONTH 11 DAY 15 YEAR 44		6. AGE (IN YEARS (LAST BIRTHDAY) 41 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>		MONTH DAY YEAR Nov 14 1986 04 AM	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY contractors					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 482		21783	
14. FATHER'S NAME FIRST William		MIDDLE F.		LAST Bramel		15. MOTHER'S MAIDEN NAME FIRST Sue		MIDDLE Mae		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. GIVE WAR OR DATES Viet Nam		16c. SOCIAL SECURITY NO. 227-60-5679		17. INFORMANT Charlotte Bramel, Smithsburg, Md.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> ond in my opinion											
ACTUAL SIGNATURE <u>H.N. Weeks</u>		TITLE (SPECIFY) M.D. <u>D.P.</u>		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) <u>H.N. Weeks</u>		ADDRESS <u>580 Norton Av. Hagerstown Md.</u>		DATE SIGNED <u>Nov 14 86</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 17, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery							
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME <u>415 E. Wilson Blvd.</u> , Hagerstown, Md. 21740		ADDRESS		25a. DATE REC'D. BY REGISTRAR Nov 18 1986							
				25b. REGISTRAR'S SIGNATURE <u>Lia J. Minnich</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place in envelope carbon paper pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or item 18 shows any injury for other than a traumatic event, the medical certification must be handwritten.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												66 331 6						
1 - STATE REGISTRAR			REG. NO. _____															
1. DECEASED NAME (TYPE OR PRINT)			FIRST Blucher			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
12 ALBERT B. CHARLTON												11-29-86				6:35 P.M.		
SEX MALE			RACE CAUCASIAN			5. DATE OF BIRTH			MONTH 6 DAY 27 YEAR 99			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
												87 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pinesburg, Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Washington						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY farmer & floor sander				
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 304 Clinton Avenue 21740						
14. FATHER'S NAME FIRST Adam			MIDDLE B.			LAST Charlton			15. MOTHER'S MAIDEN NAME FIRST Annie			MIDDLE			LAST Dowin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-26-2056			17. INFORMANT Patricia A. Harbaugh, Hagerstown, Md.						ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year several years</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>arteriosclerotic heart disease</i>																		
(c) <i></i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Cerebral vascular accident; generalized arteriosclerosis</i>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																		
22b. SIGNATURE <i>Edward J. Turley Jr.</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>												22c. DATE SIGNED <i>12/10/86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Dec. 3, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Mem. Park			23d. LOCATION CITY OR TOWN Williamsport, Wash., Maryland									
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i> ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 3 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event,

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 33147

1 - FOR
STATE
REGISTRAR LESTER ROBERT CLARK

REG. NO.

DECEDENT NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Lester Robert Clark				11-7-86				25 P.M.			
1. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	01	17	27	59	YRS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland	U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Washington County						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown	Washington County Hospital			Truck Driver			Own Business				
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland				Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Route # 4 Box 39		21740
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
George	Robert		Clark	Beulah			LAST	Beard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No	---	---	219-20-2952	Phyllis E. Clark			Route # 4 Box 39				Hagerstown, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>G. Phree d. m.</i> DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
<i>ABDUL WAHAB, MD</i>				22e. ADDRESS <i>1610-OAK HILL AVE. HAGERSTOWN, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.	STATE					
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR 11-14-86	25b. REGISTRAR'S SIGNATURE						



W 518450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be photocopied for use at the burial permit), then please return certificate to us. Pages 1 and 2 should be held until 72 hours after death.

IMPORTANT: If item 21 is marked as item 22 there may injury, or either traumatic event. The medical examiner will determine if it is

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 33150

1 - STATE REGISTRAR			REG. NO.											
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>Anne Louise Gillikin</i>						11 29 86			6 25	6 24 M				
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
						September 13, 1903			83 YRS.					
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher			12b. KIND OF BUSINESS OR INDUSTRY school board					
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 108 Park Lane 21740		
14. FATHER'S NAME FIRST Hiram			MIDDLE Short			15. MOTHER'S MAIDEN NAME FIRST Emma			MIDDLE			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-36-3869			17. INFORMANT Mr. Alfred P. Gillikin, Hagerstown, MD.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/17/86		
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			18b. IMMEDIATE CAUSE (a) (b) Arterial Thrombosis (c) Organic Brain Syndrome											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Organic Brain Syndrome														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 11/17/86 , to 11/24/86 , that (I) (we) last saw the deceased alive on 11/28/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE Sidney Novotny			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 11/24/86					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY NOVOTNY			22g. ADDRESS FUNKSDOWN MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Dec. 2, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery			23d. LOCATION CITY OR TOWN Queen Anne, Queen Annes, MD.					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR DEC 4 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandace								
415 E. Wilson Blvd., Hagerstown, Maryland 21740														

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME <small>(NAME OF DECEASED)</small>			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Persley</i>					<i>Corry</i>	<i>Nov. 28, 1986</i>				<i>10: A.M.</i>	
3. SEX		RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Black	MONTH	DAY	YEAR	72	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Gaffney, S.C.		USA					<i>Silver Spring Md.</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		11801 Caplinger Rd.			Laborer			Private			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
D.C.		Silver Sp.		Washington		XX		1706-C Street, 20002		<i>immed.</i>	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		UNK.			Grace Corry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No		579 01 9934			Jeanette Littlejohn Silver Spring						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio vascular arrest</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(b) <i>colon cancer</i>											<i>3 months</i>
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <i>(the hospital)</i> attended the deceased from <i>OCT. 2, 1986</i> to <i>Nov. 28, 1986</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>NOV. 14, 1986</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>I did not view the body after death.</i>											22g. DATE SIGNED
22h. SIGNATURE		22i. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22j. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						<i>11/28/86</i>			
Aron Primack M.D.		106 Irving St. N.W. Wash. D.C.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		12/3/86		Family Cemetery			Eden, N.C.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25. DATE REC'D. BY REGISTRAR			25. REGISTRAR'S SIGNATURE			
R.N. Horton Co. Morticians		600-Kennedy			DEC 10 1986			<i>Julie Sanderson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used if more time is required.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled in within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

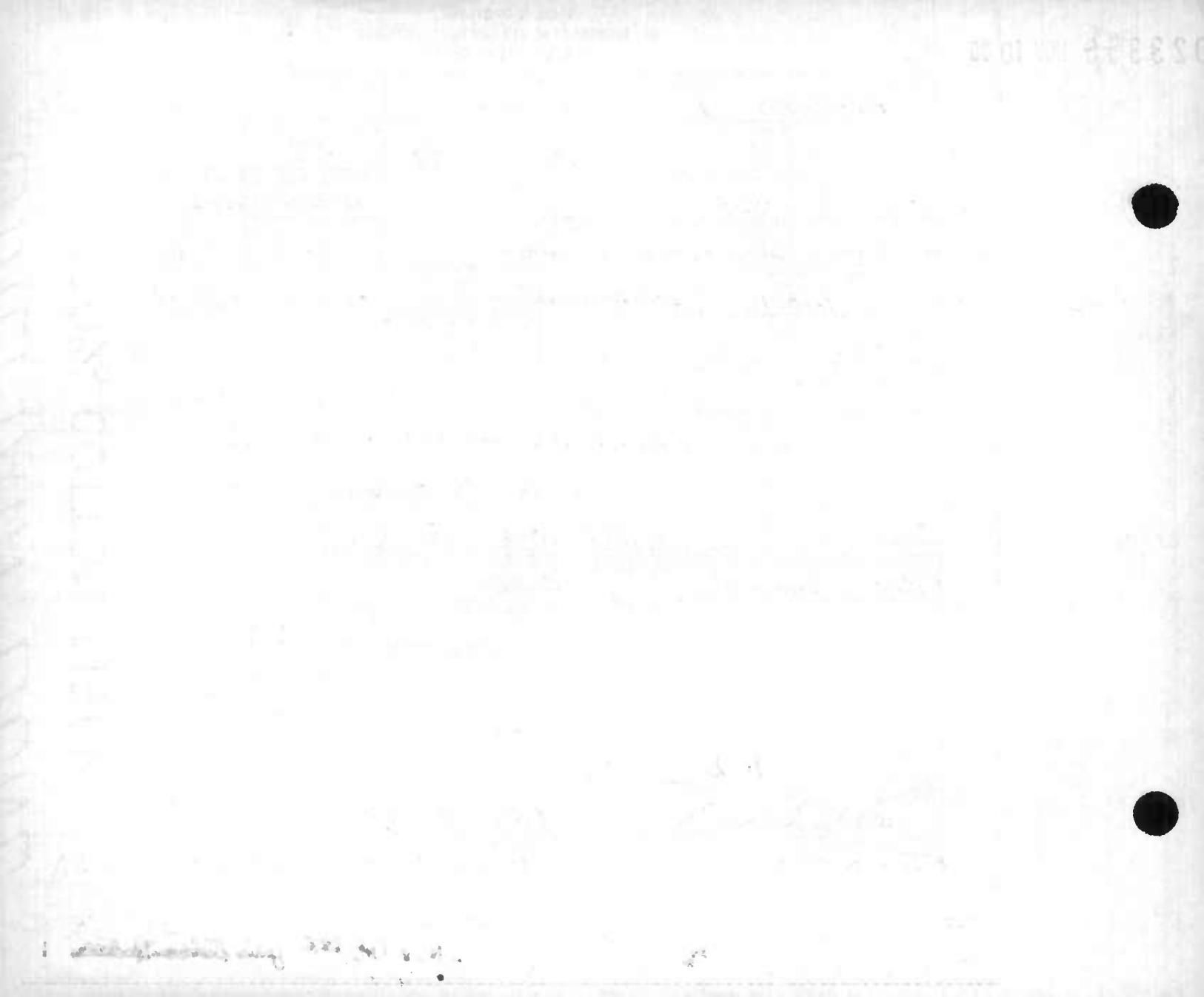
IMPORTANT:

If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 OCT 1986 152				
1. DECEASED NAME (TYPE OR PRINT)		FIRST BERNARD L.		LAST CRAMER	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
3. SEX m		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 12 1 87	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON		MD.		
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON Co. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mechanic	12b. KIND OF BUSINESS OR INDUSTRY Grove Mfg.				
13a. STATE MO.		13b. COUNTY WASH.		13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 5 Box 360 21740		
14. FATHER'S NAME FIRST David		MIDDLE N.		LAST Cramer	15. MOTHER'S MAIDEN NAME FIRST Susie		MIDDLE LAST L. Cordell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-14-9640		17. INFORMANT Dorothy J. Cramer, Hagerstown, Md.	ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))				DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE Myocardial Infarction					
				DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION ASCVD					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ESRD on Hemodialysis, COPD.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-2-86 , to 11-2-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ernesto		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZA		22g. ADDRESS 100 Long Meadow Drive Hagerstown MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 5, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		COUNTY STATE	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		ADDRESS 415 E.Wilson Blvd., Hagerstown, Md. 21740		25. DATE RECEIVED BY REGISTRAR NOV 6 1986		26. REGISTRAR'S SIGNATURE Julia Deacon			

22-01-1971 0222850



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (or used as the burial/transit permit). Then please remove certificate from this form. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, attach a separate sheet giving full details.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 33153
1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>Helen</i>	MIDDLE <i>L</i>	LAST <i>Crawford</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>11 11 1986</i>	2b. HOUR <i>M</i>
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR <i>9 27 1919</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 67	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington County	MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Designer	12b. KIND OF BUSINESS OR INDUSTRY Florial		
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11 W. Baltimore St. 21748	
14. FATHER'S NAME FIRST Paul	MIDDLE Edward	LAST Rider	15. MOTHER'S MAIDEN NAME FIRST Pearl	MIDDLE V.	LAST Bohrer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-7201	17. INFORMANT Jo Linda Peterson	ADDRESS Thousand Oaks, Calif. 21360	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>hypertension</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>cardiovascular</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>11-6-86</i> , 19 <i>86</i> , to <i>11-11-86</i> , 19 <i>86</i> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <i>11-6-86</i> , 19 <i>86</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did (did not) view the body after death.					
22b. SIGNATURE <i>J. Minnich</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>11-12-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-14-86	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	23d. LOCATION CITY OR TOWN Hagerstown Wash. Md.	23e. COUNTY	STATE
24. FUNERAL DIRECTOR NAME Gerald N. Minnich	ADDRESS 305 N. Potomac St. Hagerstown, Maryland	25a. DATE REC'D. BY REGISTRAR NOV 17 1986	25b. REGISTRAR'S SIGNATURE <i>Julia Minnich</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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DHMH - 16 60M 7/84
(VRA 15, 4)

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Warren	MIDDLE R	LAST Dannelley	20. DATE OF DEATH 11 25 86	MONTH YEAR 2b. HOUR 7:30p M		
15. DECEASED SEX Male			4. RACE White	5. DATE OF BIRTH 04 26 '03	6. AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? US	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center			12a. USUAL OCCUPATION Type of work for most of working life Tavern Owner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Pennsylvania			13b. COUNTY Fairfield			13c. STREET ADDRESS / ZIP CODE 1604 Iron Springs Rd.			
14. FATHER'S NAME FIRST Elmer			15. MOTHER'S MAIDEN NAME FIRST Emma					LAST Davis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 205-07-4705			17. INFORMANT Mildred McGlaughlin, Fairfield, PA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sick-sinus syndrome</u>					Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first			DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA with right hemiplegia</u>					Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct 10</u> , 19 <u>86</u> , to <u>Nov 25</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov 25</u> , 19 <u>86</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <u>Kyung S. Kim</u>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 11-25-86		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Kyung S. Kim, M.D.			22g. ADDRESS 1500 Pennsylvania Avenue Hagerstown, MD 21740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/29/86			23c. NAME OF CEMETERY OR CREMATORIAL Fairfield Union Cemetery		23d. LOCATION CITY OR TOWN Fairfield Adams PA	
24. FUNERAL DIRECTOR NAME Robert J. Monahan			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 27 East Main Street Fairfield, PA 17320						

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DIVISION OF VITAL RECORDS 201 W PENTAGON ST BALTIMORE MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL. ITEM #1, GAVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR ALONG WITH FORM #3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRUST RECEIPT PAGE 1 AND 2 SHOULD BE TIED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 20TH AVENUE STREET

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

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FIRST		MIDDLE	LAST		2a DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR	
HUBERT		EARL	DAVIS		X Nov. 1 1986		7:00 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1929	6. AGE (IN YEARS LAST BIRTHDAY) 56 yrs.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. IF UNDER 24 HRS. HOURS 0	10. IF UNDER 24 HRS. MIN 0	11. DATE PRONOUNCED DEAD Nov. 2 1986
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 159 South Potomac Street		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY Military		
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 159 South Potomac Street	21740		
14. FATHER'S NAME FIRST Lloyd		MIDDLE A.	LAST Davis Sr.	15. MOTHER'S MAIDEN NAME FIRST Carrie	MIDDLE Edith	LAST Bowers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1950-1974		17. INFORMANT Sonja A. Gates	ADDRESS 225 Green Mountain Dr. Maugansville, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MOMENTS		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I DEATH WAS CAUSED BY: E-913 - STRANGULATION</p> <p>9139 IMMEDIATE CAUSE (a) E-913 - STRANGULATION Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</p> <p>(b) (WITH RECENT SEIZURE DUE TO EPILEPSY) #345 DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) DUE TO, OR AS A CONSEQUENCE OF</p>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 7:00 MONTH NOV. DAY 1 YEAR 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) SUFFERED SEIZURE; COLLAPSED AND DEVELOPED LARYNGEAL SPASM			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET 159 S. POTOMAC STREET, CITY OR TOWN HAGERSTOWN, WASH., MD.		CITY OR TOWN COUNTY STATE		
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>.</p> <p>ACTUAL SIGNATURE <i>Edward W. Ditto</i></p> <p>EXAMINER'S NAME EDWARD W. DITTO, III, M.D.</p> <p>TITLE (SPECIFY) DEPUTY</p> <p>M.D. MEDICAL EXAMINER</p> <p>217 WEST WASHINGTON STREET</p> <p>ADDRESS HAGERSTOWN, MARYLAND 21740</p>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-5-86	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.		ADDRESS	25a. DATE REC'D. BY REGISTRAR NOV - 7 1986		25b. REGISTRAR'S SIGNATURE <i>K. Coffman</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires this certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician and completely filled in by the funeral director page 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the funeral director until the time of burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate should be detached from this certificate and completed by the medical examiner.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	11 21 86									6:15 AM		
Doris Nettie Davison				R	Davison												
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
female			white			July 27, 1911			75 yrs			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			U.S.A.						Washington								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Hagerstown			Washington County Hospital									secretary					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21740				
Maryland			Washington		Hagerstown					1871 Downsville Pike							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Samuel			S.		Kline	Bertha			no			220-16-0106			Mr. Linn S. Davison, Hagerstown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiogenic Shock									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy.									hours					
			DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease									months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 11-18 1986 to 11-21 1986, that (I) (was) not saw the deceased alive on 11-20 1986, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (was) (not) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Charles P. Spencer</i>			22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-21-86								
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles P. Spencer</i>			22e. ADDRESS <i>1198 Kirby Ave Hagerstown MD</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE burial Nov. 25, 1986			23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland			COUNTY STATE					
24. FUNERAL DIRECTOR NAME			MINNICH FUNERAL HOME ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 26 1986			25b. REGISTRAR'S SIGNATURE <i>Julietha Spencer</i>								
415 E. Wilson Blvd., Hagerstown, Maryland 21740																	

WITNESS

i

RECORDED AND INDEXED
JULY 20 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and filed with the State Dept. of Health and Mental Hygiene prior to burial or removal. IMPORTANT: If item 21 is marked as item 28 shows any injury, an additional certificate must be issued.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3315			
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE C	LAST DEMARCO	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
MALE			white	June 6, 1923			63 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
New Jersey			USA										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Washington County Hospital			maintenance			janitorial Serv				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland	Washington	Hagerstown				229 W. Lincoln Ave. 21740							
14. FATHER'S NAME			FIRST James	MIDDLE V.	LAST DeMarco	15. MOTHER'S MAIDEN NAME			FIRST Antoinette	MIDDLE	LAST Puleo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
yes			W.W.II			Helen DeMarco, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) ventricular fibrillation													
DUE TO, OR AS A CONSEQUENCE OF (b) coronary heart disease													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED				
John P. Lois III													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
John P. Lois III													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
burial			Nov. 21, 1986			Greenlawn Mem. Park			COUNTY				
									STATE				
24. FUNERAL DIRECTOR			MINNICH FUNERAL HOME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
NAME			415 E. Wilson Blvd., Hagerstown, Maryland 21740						NOV 24 1986			Julia Dindor-Readers	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be detached for use with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33155			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Fannie			NNM		DITMER	November 1, 1986							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.			
female		white		May 15, 1894		92 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.							
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1703 Broadfording Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife				12b. KIND OF BUSINESS OR INDUSTRY 21740			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1703 Broadfording Road					
14. FATHER'S NAME John		MIDDLE A.	LAST Socks	15. MOTHER'S MAIDEN NAME Sarah						LAST Young			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-10-6895		17. INFORMANT Mr. John A. Ditmer, Hagerstown, Maryland		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for item 18 and item 21.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Cerebrovascular Disease 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 17, 1986, to Oct 31, 1986, that (we) last saw the deceased alive on Oct 31, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.													
22b. SIGNATURE Robert Brull		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/3/86							
22e. ADDRESS 1459 Potomac Ave. Hagerstown													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE burial Nov. 4, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		23e. COUNTY		STATE			
24. FUNERAL DIRECTOR NAME 415 E.Wilson Blvd., Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 06 1986											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33:59				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>Martha Haines Downs</i>						<i>11-1-86</i>			<i>NOV</i>	<i>1</i>	<i>1986</i>	<i>620 P M</i>		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
<i>Female</i>			<i>Cauc.</i>		<i>March 21, 1907</i>		79			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Pennsylvania</i>			<i>U.S.A.</i>				<i>Washington</i>			<i>Washington</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
<i>Hagerstown</i>			<i>Washington County Hospital</i>		<i>housewife</i>					<i>21740</i>				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
<i>Maryland</i>			<i>Washington</i>		<i>Hagerstown</i>					<i>1601 Sherman Avenue</i>				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			<i>James</i>		<i>Gormley</i>				<i>Martha</i>		<i>Lewis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS						
<i>no</i>			<i>217-32-7410A</i>		<i>Mr. Clyde L. Downs, Hagerstown, Maryland</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos +</i>				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from _____, 19 <i>78</i> , to <i>Nov 1</i> , 19 <i>86</i> , that (I) <input type="checkbox"/> (we) last saw the deceased alive on <i>Nov 1</i> , 19 <i>86</i> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <i>Max E. Byrkit MD</i>										DEGREE	22c. DATE SIGNED <i>11-1-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
<i>Max E. Byrkit MD</i>			<i>Williamsport MD 21795</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE		
<i>burial</i>			<i>Nov. 4, 1986</i>		<i>Riverview Cemetery</i>		<i>Williamsport, Wash., Maryland</i>							
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
<i>MINNICH FUNERAL HOME</i>					<i>NOV 06 1986</i>			<i>Alia Sander-Ladree</i>						
<i>415 E.Wilson Blvd., Hagerstown, Maryland 21740</i>														

ACCESSION NO.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

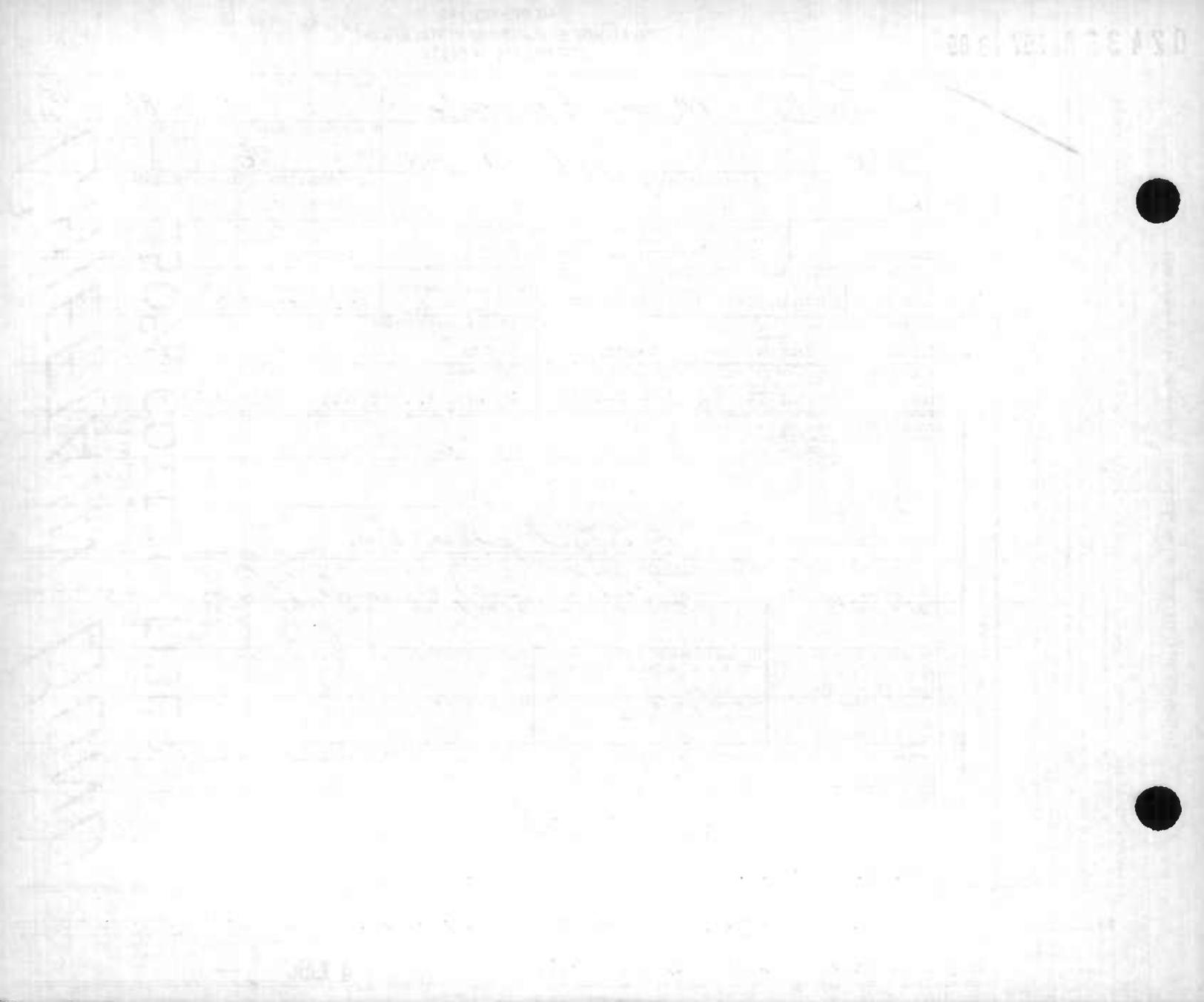
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and completely filled in by the funeral director), page 3 should be detached for use as the burial-formal permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33160			
										REG. NO.			
1. DECEASED NAME <i>(TYPE OR PRINT)</i>			FIRST <i>Jack</i>	MIDDLE <i>Maxwell</i>	LAST <i>Ebersole</i>	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 11 6 86 6:45 A.M.				
3. SEX <i>Male</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 - 01 1910</i>			6. AGE (IN YEARS LAST BIRTHDAY) 76 yrs					
7a. BIRTHPLACE STATE OR FOREIGN <i>COUNTRY Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>				
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>Rt. 3 Box# 132 21795</i>					
14. FATHER'S NAME FIRST <i>Franklin</i>			MIDDLE <i>Jacob</i>	LAST <i>Ebersole</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Eva</i>			MIDDLE -	LAST <i>Snyder</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>			16b. SOCIAL SECURITY NO. <i>WW II 216-07-1158</i>			17. INFORMANT <i>Robert B. Ebersole</i>			ADDRESS (item 13 above)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anchial Maxillary Thrombosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Anchial arteriosclerosis</i>										<i>several years</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>										<i>several years</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Pneumonia, heart failure (acute), myocardial infarction, pulmonary edema</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 84, to _____, 19 86, that (I) (we) lost saw the deceased alive on _____, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Edson B. Moody, M.D.</i>										DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>11/16/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edson B. Moody, M.D.</i>			22e. ADDRESS <i>St. James, MD</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Nov. 8, 1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Greenlawn Memorial Pk.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Williamsport Washington Maryland</i>				
24. FUNERAL DIRECTOR NAME <i>Major M. Osborne</i>			ADDRESS <i>Williamsport, MD 21795</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia L. Ladd</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the Bureau of Health and Mental Hygiene prior to burial or cremation or removal. If item 21 is marked or stamped, the medical examiner must be notified and a postmortem examination will be conducted.

IMPORTANT: If item 21 is marked or stamped, any injury, or other traumatic event, the medical examiner must be notified and a postmortem examination will be conducted.

MEDICAL CERTIFICATION

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Susan Emma Eby							November 23			1986	M
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		White		March 3, 1893			93			MONTHS	DAYS
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			9			IF UNDER 24 HRS	
PA		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY OR COUNTY OF DEATH			MONTHS HOURS MIN	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Williamsport,		Home		Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS	
MD.		Wash.		Williamsport			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 2 Box 312 Williamsport, MD.	
14. FATHER'S NAME		FIRST	MIDDLE	LAST			15. MOTHER'S MAIDEN NAME				
John		F.		Sollenberger			Elizabeth			Ebersole Sollenberger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		212-74-9948		MS. Ruth L. Eby			Rt. 2 Box 312 Williamsport, MD.			3 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardio-vascular disease											
DUE TO, OR AS A CONSEQUENCE OF (c) 6 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (We) attended the deceased from Jan. 13, 1969, to Nov. 23, 1986, that (I) (We) last saw the deceased alive on Nov. 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE <i>Max E. Byrkit</i> M.D.											
22c. DATE SIGNED 11-25-86		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Max E. Byrkit, M.D.		22e. ADDRESS 28 West Potomac Street Williamsport, Maryland 21795									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-26-86		23c. NAME OF CEMETERY OR CREMATORIAL Clear Spring Mennonite Church Cem.			23d. LOCATION CITY OR TOWN Clear Spring Wash MD.				
24. FUNERAL DIRECTOR NAME Thompson Funeral Home Inc.		ADDRESS Clear Spring, MD		25a. DATE REC'D. BY REGISTRAR NOV 27 1986			25b. REGISTRAR'S SIGNATURE Julia Saxon Andrews				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~carbon copies~~ filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33102							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
<i>Dennis E Fink, Sr.</i>						<i>11-13-86</i>				<i>4:05 P.M.</i>							
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			7. IF UNDER 1 YEAR HOURS MIN.					
<i>Male</i>			<i>White</i>			<i>November 16, 1950</i>			<i>35 yrs.</i>								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
<i>West Virginia</i>			<i>United States</i>						<i>Washington,</i>								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
<i>Hagerstown</i>			<i>Washington County Hospital</i>									<i>Rayloc</i>					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
<i>Maryland</i>			<i>Washington</i>			<i>Hancock</i>						<i>119 Limestone Road 21750</i>					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
<i>Ernest</i>			<i>L.</i>			<i>Fink</i>			<i>Mildred</i>						<i>Divelbliss</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>No</i>			<i>212 58 7560</i>			<i>Sethretha A. Fink</i>			<i>Same as 13</i>			<i>2 weeks</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute renal failure</i>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hepato Renal syndrome</i>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of liver</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic alcoholism, hepatic coma, severe jaundice</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <i>5/22/1986</i> to <i>11/13/1986</i> , that (I) <input type="checkbox"/> lost saw the deceased alive on <i>11/12/1986</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did (did not) view the body after death.																	
22b. SIGNATURE <i>Edward H. Fink Jr.</i> DEGREE																	
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED <i>11/13/86</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>11/15/1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Thomas Episcopal</i>			23d. LOCATION CITY OR TOWN <i>Hancock</i> COUNTY <i>Washington, Md.</i> STATE <i>21750</i>								
24. FUNERAL DIRECTOR NAME <i>Buried at home Hancock MD.</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>NOV 19 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson-Pandrea</i>								
DHMH - 16 60M 7/B4 (VRA 15, 4)																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and completely filled in by the attending physician. Item 1 and 2 should be filled within 24 hours after death.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST PAULINE	MIDDLE Augusta	LAST FLEMING	2a. DATE OF DEATH MONTH 11	DAY 15	YEAR 86	2b. HOUR 3:15 PM		
3. SEX Female		4. RACE white	5. DATE OF BIRTH MONTH 4			DAY 20	YEAR 86	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Elton Villa Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			12b. KIND OF BUSINESS OR INDUSTRY School			
13a. STATE W. Va.		13c. CITY OR TOWN Jefferson			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 136 Maple Ave. / 25414			
14. FATHER'S NAME FIRST George		MIDDLE Thomas	LAST Staubs	15. MOTHER'S MAIDEN NAME FIRST Mittie			MIDDLE Randolph	LAST Grove	16. SOCIAL SECURITY NO. 235-78-0276		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest			17. INFORMANT Pamela S. Hostler - Ranson, WV 25438			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		DOUE TO, OR AS A CONSEQUENCE OF (b) Obstructive jaundice									
		DOUE TO, OR AS A CONSEQUENCE OF (c) Diabolo									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) not view the body after death.											
22b. SIGNATURE Q. P. WALTERS, M.D.		22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/15/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAITER, M.D.		22e. ADDRESS 1610 - OAK HILL AVE. HAGERSTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/18/86		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery			23d. LOCATION CITY OR TOWN Loudoun Hts., Loudoun, Va.		23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME Robert L. Spencer - Harpers Ferry, WV 25425		ADDRESS Drawer C			25a. DATE REC'D. BY REGISTRAR NOV 21 1986			25b. REGISTRAR'S SIGNATURE Jean Davidson-Randall			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (LIVE OR PRINT)			FIRST <i>SAMUEL</i>	MIDDLE <i>Benjamin</i>	LAST <i>GAINES</i>	2a. DATE OF DEATH MONTH YEAR	MONTH DAY YEAR	2b. HOUR 11 20 86 10:28 AM					
3. SEX <i>M</i>		4. RACE <i>C</i>	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Hagerstown</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i>					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Williamsport</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. # 2, Box 166 <i>21795</i>					
14. FATHER'S NAME FIRST <i>Isacc</i>		MIDDLE <i>Newton</i>	LAST <i>Gaines</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Adda</i>			MIDDLE <i></i>	LAST <i>Manning</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-09-5093</i>			17. INFORMANT ADDRESS <i>Route 10, Box 79 Wanda Mertz Hagerstown, Maryland</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>CARDIAC ARREST</i>			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>MYOCARDIAL INFARCTION</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Cerebrovascular Accident, Diabetes Mellitus</i>										19. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>11/20/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>11/20/86</i>			
22b. DEGREE <i>Attending Physician</i>										22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN			
22e. ADDRESS <i>879 Commonwealth Ave</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Nov. 21, 1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Smithsburg Crematory</i>			23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR <i>NOV 24 1986</i>				
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>		25a. ADDRESS <i>\$!% E. Wilson Blvd. Hagerstown, Maryland 21740</i>			25b. REGISTRAR'S SIGNATURE <i>via Jander-Pandale</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be distributed for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner may be notified at time of death.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86 3316	
												REG. NO.	
1 - FOR STATE REGISTRAR			CEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
Thomas L			Gibson			11 15 86			2:25 p.m.				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 11 DAY 8 YEAR 1903			6. AGE (IN YEARS LAST BIRTHDAY) 83			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor			12b KIND OF BUSINESS OR INDUSTRY P.E. Power				
13a STATE Maryland			13b COUNTY Washington			13c CITY OR TOWN Hagerstown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 1038 Brinker Dr. Apt. 201	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas L. Gibson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Coulter										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 217-10-9472			17. INFORMANT Camilla M. Gibson same as 13			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of The Prostate</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>glan with widespread bony</u>													
(c) <u>metastases & Terminal Uremia & Sepsis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
21g. I certify that (I) this hospital attended the deceased from <u>10/18/86</u> to <u>11/15/86</u> , that (I) we last saw the deceased alive on <u>11/15/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22a. SIGNATURE Robert Brull			22b. DEGREE M.D.			22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11/15/86				
22e. ADDRESS 1459 Potomac Ave. Hagerstown													
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 11-18-86			23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown				
24. FUNERAL DIRECTOR NAME Gerald N. Minnich			25a. DATE REC'D. BY REGISTRAR NOV 24 1986			25b. REGISTRAR'S SIGNATURE Julie Schaefer							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS OF DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE TOP LEFT CORNER OF PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (OR TO FUNERAL DIRECTOR) PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 33100

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR 5:40 PM	
LARRY	Neal	GLOVIER	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nov 15	1986			
J. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 5:40 PM	
Male	Caucasian	Mar. 3, 1955	31 yrs.	MONTHS	DAYS	HOURS	MIN	Nov 15	1986		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA				Washington						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION, TYPE OF WORK FOR MOST OF WORKING LIFE					12b. KIND OF BUSINESS INDUSTRY
Hagerstown	Washington County Hospital					Asst. Service Manager					Herb Gordon Auto World
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			14. STREET ADDRESS					
Maryland	Baltimore	Elkridge	YES	<input type="checkbox"/>	NO	<input checked="" type="checkbox"/>	6684 Duckett's Lane			21227	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. ADDRESS					
T.		Glovier	Eddie	Lou					Hunsucker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No	219-64-4513	Paula Glovier Wife Same as 13			Sudden						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8189 IMMEDIATE CAUSE (a) BASAL SKULL FRACTURE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (g)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 P.M. Nov 15 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) thrown from motor vehicle			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Maryland			21f. LOCATION STREET RT 70 CITY OR TOWN MD CLEARSpring			CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE	TITLE (SPECIFY) M.D.			22b. MEDICAL EXAMINER			DATE SIGNED Nov 15, 86				
EXAMINER'S NAME (TYPE OR PRINT)											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial	Nov. 19, 1986	George Washington Cem.			Adelphi			Prince Georges		Md.	
24. FUNERAL DIRECTOR NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Francis J. Collins, Jr.	500 University Blvd., W. Silver Spring, Md.			NOV 21 1986			Julia Dawson, Registrar				

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1923. *Journal of the Royal Society of Medicine*, 16, 100-101.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 3316
NAME AND NAME			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR
James Joseph Gray Sr.						11	11	1986		
1. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS	
Male	White	MONTH	DAY	YEAR	57	MONTHS	DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania	U.S.A.	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Washington County MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown	Washington County Hospital Supervisor			2311 Dixie Drive 21740			Publishing			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland	Washington	Hagerstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2311 Dixie Drive 21740				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	
Lewis	John		Gray	Mary			Elizabeth		Mc Nally	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Yes	Korean 193-20-1289			Lucille Ann Gray same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible acute myocardial infarction</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Obesity</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Copilot syndrome</i> (b) <i>Heavy Cigarette Use</i> (c) <i>Pneumonia</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>11/14/86</i> , 19 <i>86</i> , to <i>11/15/86</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>11/15/86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>11/13/86</i>
22b. SIGNATURE <i>A. Carl Anderson</i> DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. Carl Anderson</i>			22e. ADDRESS <i>363 South Clemons Ave. Hagerstown MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>11-14-86</i>	23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN Hagerstown Wash. Md.					
Burial		Rose Hill Cemetery								
24. FUNERAL DIRECTOR NAME	305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR <i>NOV 21 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Jim Simon Anderson</i>			
Gerald N. Minnich	Hagerstown, Maryland									

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRAVEL DOCUMENT. IT SHOULD BE KEPT WITH PAGES 1 AND 2. IT SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL Cremation, or other

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR	
Arthur			Seymore	Grimm		<input checked="" type="checkbox"/>	Nov. 16,	1986			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	7d. HOUR	
Male	White	9 - 24 - 1922	64			November 19,	1986		9:40 a.m.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Keedysville		Rt 1 Box 138				Metal Work		Aircraft			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Keedysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 138 21756			
14. FATHER'S NAME FIRST Luther		MIDDLE Olin		LAST Grimm		15. MOTHER'S MAIDEN NAME FIRST Fannie		16. SOCIAL SECURITY NO. 217-16-2603			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. World War II		17. INFORMANT Mrs F. Catherine Daugherty Hagerstown Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (414)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u> M.D. Deputy MEDICAL EXAMINER											
TITLE (SPECIFY) DATE SIGNED 11/19/86											
EXAMINER'S NAME TYPE OR PRINT Howard N. Weeks, M.D. ADDRESS 580 Northern Ave., Hag. Md. 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11-22-86		23c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery 21713		23d. LOCATION CITY OR TOWN Rohrersville		COUNTY Washington			STATE Md.
24. FUNERAL DIRECTOR NAME John H. Bast Jr.		ADDRESS Rt. 4 Box 7 Boonsboro Md.		25a. DATE REC'D. BY REGISTRAR NOV 24 1986		25b. REGISTRAR'S SIGNATURE <u>John H. Bast Jr.</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please enclose carbon copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked on item 18 show any injury, or other traumatic event, it must be initialed and dated.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Harry Francis Harshman							11	20	86	8:05 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Male		Cauc.		MONTH	DAY	YEAR	80	MONTHS	YEARS	IF UNDER 24 HRS.	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Md.		U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Colton Villa Nursing Center					mechanic			equipment	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			21769	
Md.		Frederick	Middletown				8003 Old Hagerstown Rd.				
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	16. ADDRESS			LAST
Charles			Harshman		Esta			Middletown, Md. 21769			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		213-12-7460			Vada Harshman						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
Q. Sheel u									11/20/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Aboul Wahed MD		crossan 1619- Oak Hill Ave. HAGERSTOWN MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION STREET						
Burial		of Brethren Cem.			Myersville Fred. Md.						
24. FUNERAL DIRECTOR NAME		21769			25a. DATE REC'D. BY REGISTRY			25b. G			
Thompson Funeral Home		Middletown, Md.			NOV 26 1986			yesterda			

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1. *Aboriginal Art 2000 S.V.O.H.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Nola	MIDDLE Mae	LAST HARSHMAN	20. DATE OF DEATH MONTH DAY YEAR November 6, 1986	2b HOUR 4:00 P.M.		
3. SEX female		4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1908			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) electrician			12b. KIND OF BUSINESS OR INDUSTRY aircraft	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Colton Villa 21740		
14. FATHER'S NAME FIRST J.		MIDDLE C.	LAST Johnson	15. MOTHER'S MAIDEN NAME FIRST Lena			MIDDLE	LAST Morgan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.			17. INFORMANT Leon N. Harshman, Hagerstown, Maryland			APPROXIMATE INTERVAL BETWEEN CONSENT AND DEATH 10 - 12 DAYS	
<p>18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY CONGESTIVE HEART FAILURE</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) _____</p>									10 - 15 yrs.
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</p> <p>DIABETES MELLITUS TYPE I</p>									
19a. DATE OF OPERATION 10/24/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAPAROTOMY FOR CHOLELITHIASIS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____				
<p>22a. I certify that (I) XXXXXX, attended the deceased from OCTOBER 9, 1986, to NOVEMBER 6, 1986, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on NOVEMBER 6, 1986, and that in (my) XXXXXX opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death.</p> <p>22b. SIGNATURE <i>Edward W. Ditto, III</i></p> <p>22c. DEGREE EDWARD W. DITTO, III, M.D.</p> <p>22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.</p> <p>22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</p>									22e. DATE SIGNED Nov. 7, 1986
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 10, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland COUNTY _____ STATE _____			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR ADDRESS NOV 10 1986			25b. REGISTRAR'S SIGNATURE <i>Juia Scidmore Pendall</i>				

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GRUPO TAKI UNITARIO

GRUPO MAURICIO ENRICO DIT MURKINET

GRUPO OUTDOOR ESTADIA

MIL VICTORIANA Y VICTORIANA
GRUPO 21
GRUPO 22

00	REMOVON	00	REMOVON	00	REMOVON	00	REMOVON
	X		X		X		X

T22 T. 00711100 A. T. 300 013
T. 01 ANALYMA C. 00711100

00 00 00 00 00 00 00 00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

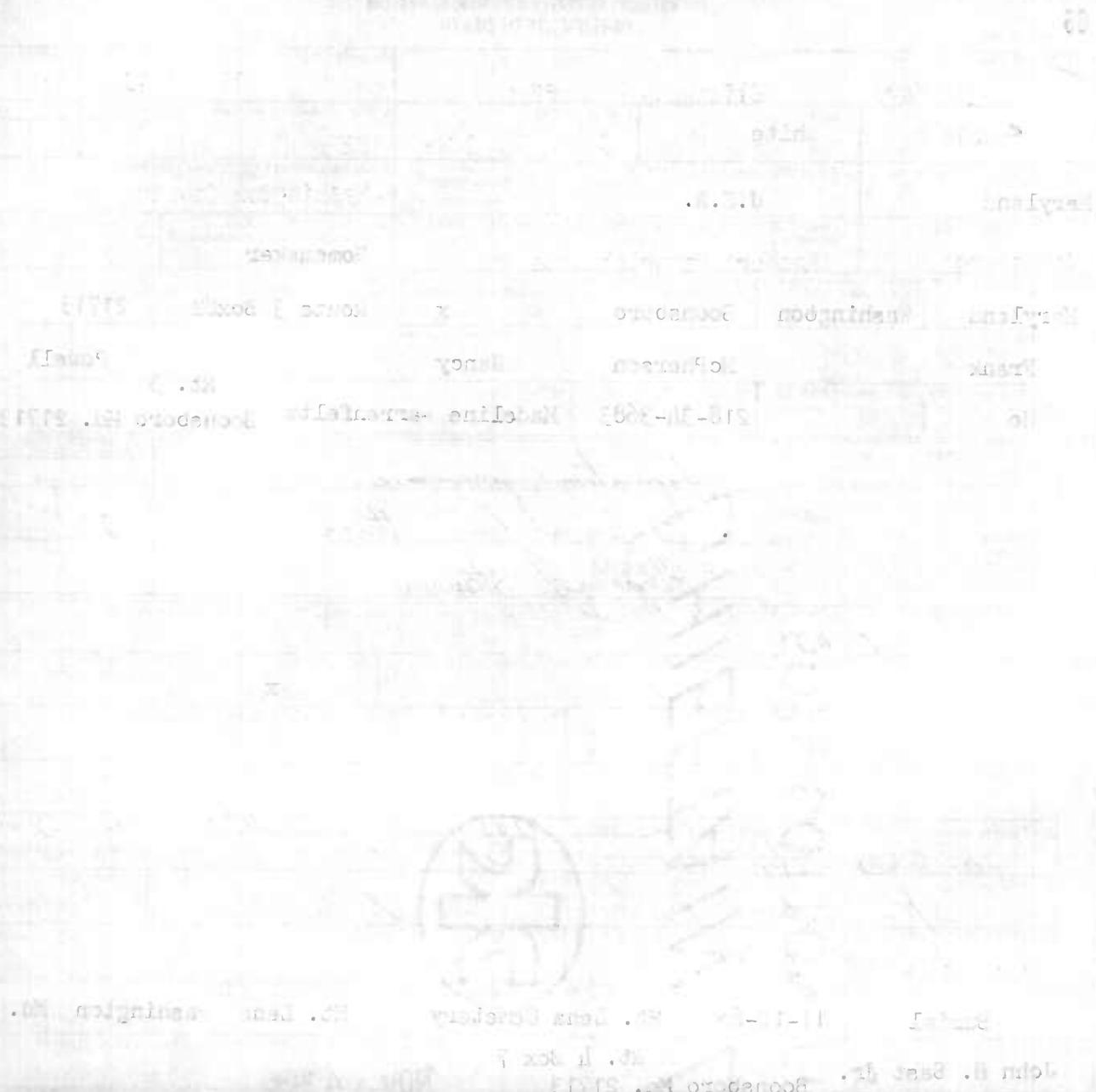
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 33171
1. DECEASED NAME (TYPE OR PRINT)	FIRST Mary	MIDDLE Elizabeth	LAST Hoffman	20. DATE OF DEATH MONTH DAY YEAR 11 7 1986	2b. HOUR 5:35 P M
1. SEX Female	4. RACE White	5. DATE OF BIRTH 6 MONTH 6 DAY YEAR 1894	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Route 3 Box 82	21713
14. FATHER'S NAME FIRST Frank	MIDDLE	LAST McPherson	15. MOTHER'S MAIDEN NAME FIRST Nancy	MIDDLE	LAST Powell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 218-34-3683	17. INFORMANT Madeline Warrenfeltz	ADDRESS Rt. 3 Boonsboro Md. 21713		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular attack</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 24 hours					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophageal stenosis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>COPD</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 1985, 19, to 1986, 19, that (I) (we) last saw the deceased alive on 11/21/86, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.					
22b. SIGNATURE <i>R.L. KUGLER, M.D., P.C.</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED P.O. BOX 246		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. KUGLER, M.D., P.C.	22e. ADDRESS P.O. BOX 246	23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 11-10-86	23c. NAME OF CEMETERY OR CREMATORIAL LOCATION Mt. Lena Cemetery	23d. LOCATION Mt. Lena	23e. CITY OR TOWN Washington	23f. COUNTY Md.	23g. STATE
24. FUNERAL DIRECTOR John H. Bast Jr.			25a. ADDRESS Rt. 4 Box 7	25b. DATE REC'D. BY REGISTRAR NOV 14 1986	25b. REGISTRAR'S SIGNATURE <i>John H. Bast Jr.</i>
			Boonsboro Md. 21713		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 6 3 3 1 1 2				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			Charles Laverne Holder			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Laverne			Holder			11 5 86						5:15 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
M			W			MONTH Nov. 25, 1917 DAY YEAR			68			MONTHS	DAYS	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Weaverton, Md.			U. S. A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Washington County Hospital			Never Employed								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Maryland		Washington		Boonsboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rfd. 4 Box 130		21713			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
FIRST John MIDDLE William LAST Holder			FIRST Ethel MIDDLE Elisa LAST Delauter											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			215- 18- 2541			Mrs. Linda Beard,			Rfd. 4 Box 138			Boonsboro, Md. 21713		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Electromechanical dissociation				
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction										10 hours				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) ASOVD														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Type II diabetes mellitus														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from now the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										19 1986 to 11/5 19 86, that (I) (we) lost				
22b. SIGNATURE <i>R.L. Kuyler MD</i>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										Geeting Lane Keedysville, Maryland			11/5/86	
23a. BURIAL, CREMATION, REMOVAL			23c. DATE			23e. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION					
Burial			11-8-86			Brownsville Hgts. Cem.			CITY OR TOWN Brownsville					
24. FUNERAL DIRECTOR			NAME			ADDRESS			COUNTY Wash. Co., Md.					
John H. Bast, Jr.			Boonsboro, Md. 21713											
25a. DATE OF REC'D. - REC'D. BY - REC'D. BY REG'D. REC'D. REC'D.										SSN				
NOV 10 1986										Julia Decker, R.N.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is filled in by a funeral director, page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, then please remove carbon paper. Page 1 may be retained by the funeral director, page 1 may be retained by the hospital or attending physician. It should be deposited for use as the burial/transit permit. Then please remove carbon paper. Page 1 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

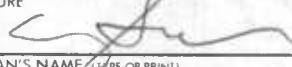
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 33173
DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Ruth Ellen Holmes			November 20, 1986	4:30 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 4, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chestnut Grove, Md. U. S. A.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rfd. 3 Box 354	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rfd. 3 Box 354 21713	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Jamison	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa May Thomas			ADDRESS Rfd. 3 Box 354 Boonsboro, Md. 21713	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (S, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 214-32-4052	17. INFORMANT Mr. Carroll A. Holmes,	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDEN		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC DYSRHYTHMIA, SUSPECTED</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ACUTE BRONCHITIS					
19a. DATE OF OPERATION NONE	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (this hospital) attended the deceased from <u>JULY 11</u> , 19 <u>70</u> , to <u>NOVEMBER 2 1986</u> , that (we) lost sow the deceased alive on <u>AUGUST 21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Barry M. Cohen</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>11-24-86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry M. Cohen	22e. ADDRESS 339 EXIT ANTETAM ST HAGERSTOWN MD, 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-24-86	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery	23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.	ADDRESS Boonsboro, Md. 21713	25a. DATE REC'D. BY REGISTRAR NOV 26 1986	25b. REGISTRAR'S SIGNATURE <u>John H. Bast</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 025903														
1 - FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Lovery					Hutzell	11 23 86					5:55	A.M.		
3. SEX			RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White		8 1 1901			85 YRS			MONTHS DAYS HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.								Washington County MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Hagerstown			Washington County Hospital									Homemaker Home		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			Washington		Hagerstown						Route #3 21740			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS					
Sep					Hutzell	FIRST MIDDLE LAST			Boonsboro, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH: Enter only one cause per line for part I(b) and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			220-54-8934		Marie Smith			10 days						
								Due to, or as a consequence of (b) Pulmonary emboli			10 days			
								(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
21a. DATE OF OPERATION 11/12/86			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED Incarcerated enlarged prostate			21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/22/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE 			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 11/23/86		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) C. Su			22g. ADDRESS 881 S. Charles St. Hagerstown Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-26-86			23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery			23d. LOCATION CITY OR TOWN Boonsboro Wash. Md.			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Gerald N. Minnich			25a. DATE REC'D. BY REGISTRAR 11/26/86			25b. REGISTRAR'S SIGNATURE 								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

026213 DEC 1 596
STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Anne Mary James						NOVEMBER 29 1986				8:08 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female		White		MONTH	DAY	YEAR	94			IF UNDER 24 HRS		
				10	15	1892	YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Wales		USA					WASHINGTON					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN		AVALON MANOR Nursing Home homemaker					home					
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland		Washington Hagerstown					5 Rowland Ave 21740					
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST					
Benjamin Price				Margaret			EVANS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		172-50-3326		Nivello Ffieffer			see # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A sepsis</u> few days yrs												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>UTI. Senile dementia, cerebral vascular</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>W. B. KONG, M.D.</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12-5-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
W. B. KONG, M.D.		1933 Va. Ave., Hagerstown, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNT		STATE		
Burial		12-3-86		Washburn St. Cem.		Seantown		Penn.				
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Gerald N. Minnich		305 N. Potomac St. Hagerstown, Md.		DEC 4 1986		Julia Dawson-Randall						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 33110			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Roy	MIDDLE Needy	LAST KNIGHT	2a DATE OF DEATH MONTH DAY YEAR November 28, 1986	2b HOUR 11:30 A.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR November 3, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 228 W. Howard Street		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed			12b KIND OF BUSINESS OR INDUSTRY grocery store	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 228 W. Howard Street 21740
14. FATHER'S NAME FIRST John		MIDDLE 	LAST Knight	15. MOTHER'S MAIDEN NAME FIRST Emma		MIDDLE 	LAST Needy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS Hazel A. Knight, Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction		DUE TO, OR AS A CONSEQUENCE OF (c) Anteroseptic Coronary Lesion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						10 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11/24/86 to 11/28/86 that (I) (we) lost saw the deceased alive on 11/24/86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b. SIGNATURE Robert Brull		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 11/29/86		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull		22f. ADDRESS 459 Potowmoc Ave. Hagerstown						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Dec. 1, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR DEC 4 1986		25b. REGISTRAR'S SIGNATURE Lia Gordon-Randall				

87-10771320



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT (PAGES 1 AND 2 SHOULD BE FILED UNINHIBITED). AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.			
1- FOR STATE REGISTRAR			LAST						2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
(DECEASED NAME (TYPE OR PRINT))			FIRST	MIDDLE				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11	1	1986	M
John			WALTER		Knott							11	1	1986	2d HOUR 8:28 a.m.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	
MALE		BLACK		AUG. 24, 1944		42 yrs.		MONTHS DAYS		HOURS MIN.		11 1 1986			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER			12b. KIND OF BUSINESS OR INDUSTRY PRIVATE			
12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE MARYLAND			12b. COUNTY CHARLES		13c. CITY OR TOWN MC CONCHIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ROUTE 6 / 20677						
14. FATHER'S NAME JAMES			MIDDLE		LAST KNOTT		15. MOTHER'S MAIDEN NAME MARY		MIDDLE		LAST NETTIE DADE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT JOSEPH L. KNOTT			ADDRESS BRYANTOWN, MD. 20617						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure disorder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
{ (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) <u>Margarita Korell, M.D. Assistant</u>			
ACTUAL SIGNATURE			MEDICAL EXAMINER									DATE SIGNED <u>11/2/86</u>			
EXAMINER'S NAME (TYPE OR PRINT)			Margarita A. Korell, M.D.						ADDRESS 111 Penn St. Baltimore, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL NOV. 6, 1986			23c. NAME OF CEMETERY OR CREMATORIUM ST. MARY'S CHURCH CEM.			23d. LOCATION CITY OR TOWN NEWPORT, CHARLES, MARYLAND			COUNTY STATE			
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME			ADDRESS POMONKEY, MARYLAND						25a. DATE REC'D. BY REGISTRAR <u>NOV 06 1986</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Dandrea</u>			
DHMH - 17 (VR A15 ME (5))															

0208 06 103

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use of the funeral director. Then please remove carbon paper, page 3 and 2 should be filled in by the funeral director - page 4 may be filled in by the funeral director - page 3

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

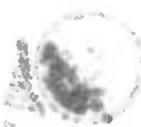
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										86 331 / 8			
CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Helen ELIZABETH LANCASTER						November 14, 1986			945 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE IN YEARS LAST BIRTHDAY			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		June 21, 1908			78						
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD						
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson			12b. KIND OF BUSINESS OR INDUSTRY Dept Store					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1037 View Street 21740					
14. FATHER'S NAME John		MIDDLE Luther		LAST Lancaster		15. MOTHER'S MAIDEN NAME Mary		16. ADDRESS 1037 View Street Hagerstown, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months - years			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. - - -			17c. INFORMANT Julia L. Lancaster								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiomyopathy</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i> Yes													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic Congestive Heart Failure with cerebral edema</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12 Oct</u> , 19 <u>86</u> , to <u>14 Nov</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>13 Nov.</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>S. J. Fender</i>		22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED <u>14 Nov. 86</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. H. Fender</i>		22e. ADDRESS <i>138 E. Antietam St., Hagerstown, Md 21740</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-18-86			23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION Hagerstown, Washington, Md.		STATE			
24. FUNERAL DIRECTOR NAME A. K. Coffman Funeral Home, Inc.,		ADDRESS Hagerstown, Md.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Jeanine Fender</i>						
NOV 19 1986													

0200 21245

GENERAL STUDIES, 1914

GOVERNMENT OF CANADA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked then Item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 86 33179			
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH DAY YEAR	2b. HOUR		
Ruth L. Lefever			Lefever	11	19 86	10 ³⁰ PM		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			
Female	Caucasian	MONTH	DAY	YEAR	79	IF UNDER 1 YEAR MONTHS DAYS		
Pennsylvania	U.S.A.	7	28	07	YRS	IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania	U.S.A.				Washington MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown	Washington County Hospital					Transportation		
13a. STATE Maryland					13b. COUNTY Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1126 Luther Drive 21740
14. FATHER'S NAME FIRST William MIDDLE Harrison LAST Love					15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE V. LAST Hosick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No 214 05 5205		17. INFORMANT Samuel H. Lefever		ADDRESS 1126 Luther Drive Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) Anterior myocardial infarction 11 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease 2 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Ventricular fibrillation, pulmonary edema, cardiac arrest								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 78 to 11 19 19 86, that (I) (we) last saw the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Edward May, M.D. DEGREE								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Nov. 22, 1986		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown Washington Md.		
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd. Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE NOV 28 1986 Julia Deidra Rendall		

00-0-21119250

Wingman - Standard

PC 100% of standard

Wingman - Standard

Wingman - Standard

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

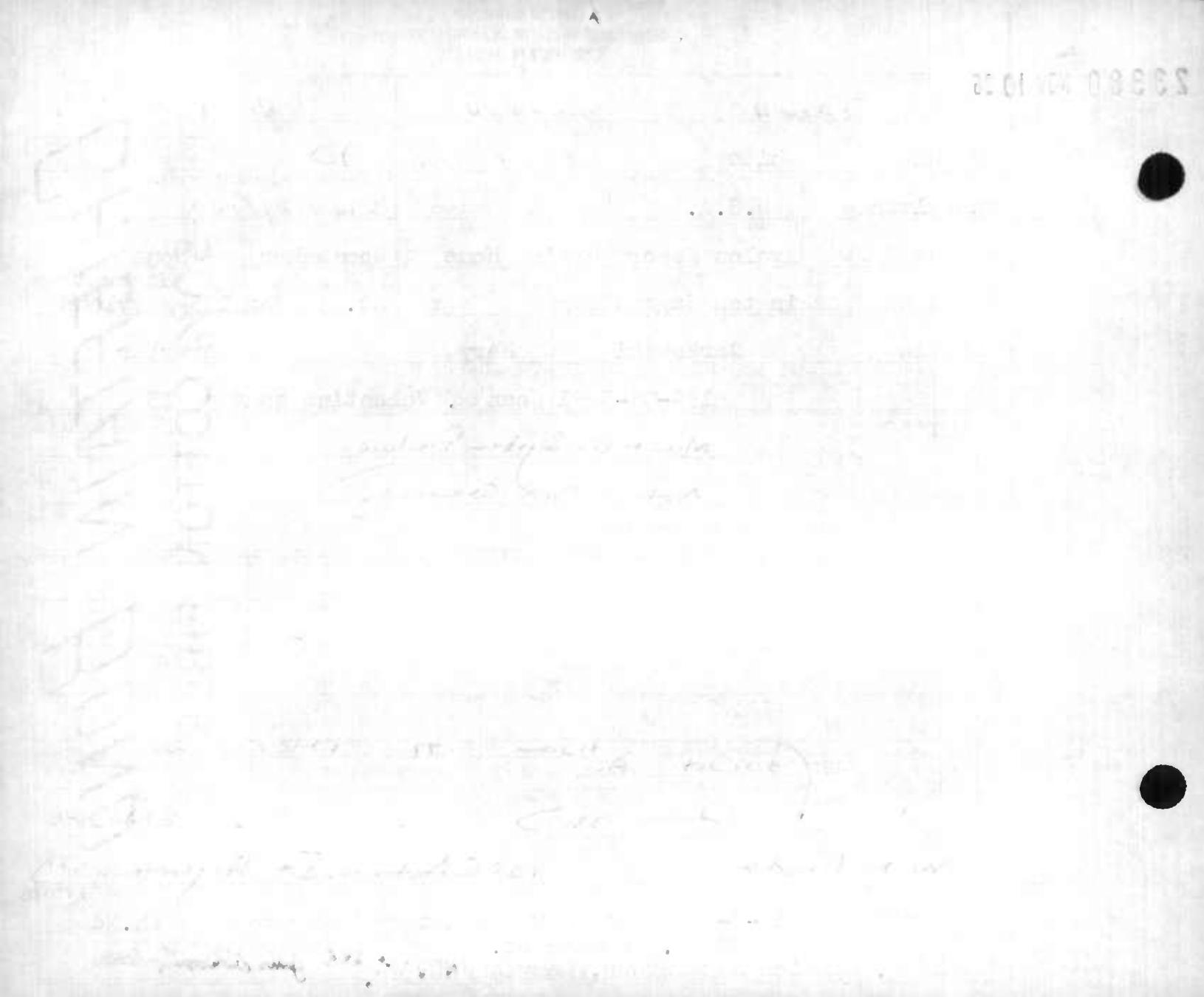
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-trust permit. Then please affix your official stamp and sign with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

MEDICAL CERTIFICATION

A STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30 33 1 30				
										REG. NO.				
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
JOANNA					LEHMAN	Nov 1	86			1:40 PM				
3c SEX	4c RACE	5c DATE OF BIRTH			6c AGE (IN YEARS LAST BIRTHDAY)	7c IF UNDER 1 YEAR	8c IF UNDER 21 HRS							
Female	White	MONTH	DAY	YEAR	90	MONTHS	DAYS	HOURS	MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		U.S.A.					WASHINGTON							
10c CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12c USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN			Avalon Manor Nursing Home			Homemaker			Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										211160				
13a STATE	13b COUNTY	13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS ZIP CODE Rt. 3 Box 195	Hagerstown						
Maryland	Washington	Hagerstown					Maryland							
14c FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Martin			Garkowski			Mary			Greyber					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS					
No			139-05-5681			Joan M. Valentine same as 13								
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
meangle System Failure														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Anterior clavicular dislocation</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>11-5-86</u> , 19 <u>77</u> , to <u>1-Nov-86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>30 Oct 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.														
22b SIGNATURE <i>S. Fender</i>										DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c DATE SIGNED <i>3 Nov 86</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS			138 E Antietam St, Hagerstown MD								
W.H. Fender														
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN					
Burial			11-5-86			Rest Haven Cemetery			Hagerstown Wash. Md.					
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Gerald N. Minnich			305 N. Potomac St.			NOV 06 1986			<i>Juliann Radner</i>					
Hagerstown, Maryland														

U.S. 03865



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troupe permit. Then please remove carbon paper. Please send 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the medical examiner.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 3318			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	REG. NO.			
<i>Joseph ARTHUR</i>			<i>Joseph</i>	<i>ARTHUR</i>	<i>Long SR</i>	<i>11 9 86</i>							
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	7b HOUR							
Male	White	<i>Sept. 2, 1909</i>			77	4:00 AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH								
Hagerstown	U.S.A.				Washington County			MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Hagerstown	495 Mitchell Avenue			Mill Worker			Organ Mfg.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
maryland	Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			495 Mitchell Avenue			21740				
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS						
John	Luther		Long	Mary Elizabeth McNamee			408 Linganore Avenue						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No	214-09-0283			Joseph A. Long Jr. Hagerstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Archie Gorst</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Electrode insulation</i>													
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c) (c) <i>Chronic cerebral vascular</i>													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <i>8/17/86</i> , to <i>10/17/86</i> , to <i>11/5/86</i> , tht <input checked="" type="checkbox"/> (we) lost above (if we died) and did not view the body after death.													
22b. SIGNATURE <i>Alvin Coffman</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>11/19/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alvin Coffman</i>			22e. ADDRESS <i>1610 Oak Hill Ave Hagerstown MD</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE <i>11-12-86</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Rest Haven Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Hagerstown Washington, Md.</i>				
24. FUNERAL DIRECTOR NAME <i>A.K. Coffman Funeral Home, Inc. Hagerstown, Md.</i>			25a. DATE REC'D. BY REGISTRAR ADDRESS <i>NOV 14 1986 Julia Sanderson</i>			25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove contribution slip and attach to the burial/transit permit. This certificate and the burial/transit permit should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the deceased.

IMPORTANT: If Item 21 is marked "YES" show any injury or other traumatic condition which contributed to the death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 33182					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>Clarence E. Loveless</i>						<i>November 12, 1986</i>						<i>8:20 P.M.</i>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
<i>Male</i>		<i>White</i>		<i>JAN. 14 1916</i>			70			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
<i>Washington</i>		<i>U.S.A.</i>					<i>Washington County</i>								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
<i>Williamsport</i>		<i>Williamsport Nursing Home</i>					<i>Superintendent Cemetery</i>								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
<i>Maryland</i>		<i>Howard</i>		<i>Marriotsville</i>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<i>Route 2 21101</i>						
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
<i>Elijah</i>				<i>Loveless</i>			<i>Adeline</i>				<i>Miller</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS								
NO		<i>?</i>					<i>Maggie Wilson Marriotsville, MD 21101</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 YRS.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastatic IntraCRANIAL Tumor</i> Due to, or as a consequence of (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 3, 1986</i> to <i>11-11-86</i> , that (I) (we) last saw the deceased alive on <i>November 6, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>J. E. Howe.</i>										DEGREE					
										ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ted E. Howe.</i>										22e. ADDRESS <i>18201 Marden Lane, Olney Md 20832</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
BURIAL		<i>11-11-86</i>		<i>CRESTLAWN MEM. GARD.</i>			<i>MARIOTTSVILLE HOWARD</i>				<i>MD</i>				
24. FUNERAL DIRECTOR NAME <i>HAIGHT FUNERAL HOME SYKESVILLE, MD 21784</i>										25. DATE REC'D. BY REGISTRAR REG. CARD SIGNATURE <i>NOV 12 1986 Julie Deacon-Lindell</i>					

2021 RELEASE UNDER E.O. 14176

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, resided by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. It should be filed within 24 hours after death.

IMPORTANT: If Item 21d is marked or Item 18 shows only injury, do either Item

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.
I. DECEASED NAME (TYPE OR PRINT)	FIRST <i>Miriam</i>	MIDDLE <i>Elaine</i>	LAST <i>MARKER</i>	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR 11-13-86 2:45 AM
3. SEX Female	4 RACE White	S. DATE OF BIRTH MONTH October DAY 29 YEAR 1926	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i>		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales Clerk</i>	
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>709 Summit Avenue 21740</i>	
14. FATHER'S NAME FIRST <i>Ross</i>	MIDDLE <i>Martin</i>	LAST <i>Gantz</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Carrie</i>	MIDDLE <i>Estelle</i>	LAST <i>Cline</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. <i>213-24-9534</i>	17. INFORMANT <i>Rolland P. Marker</i>	18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ RESPIRATORY ARREST BACONCHOCYGENIC CA RADIATION pneumonitis		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Dwight Wooster</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>11/13/86</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dwight Wooster</i>	22e. ADDRESS <i>1825 Howell Rd / HAGST. MD -</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-15-86	23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery	23d. LOCATION CITY OR TOWN Boonsboro	COUNTY Washington	STATE Maryland
24. FUNERAL DIRECTOR NAME <i>John H. Bast Jr.</i>	ADDRESS <i>Rt. 4 Box 7 Boonsboro, Maryland 21713</i>	25a. DATE REC'D. BY REGISTRAR NOV 17 1986	25b. REGISTRAR'S SIGNATURE <i>John H. Bast Jr.</i>		

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FOR
STATE
REGISTRAR
1-3-86STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, READING WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MICHEL JOSEPH	MIDDLE 	LAST MCKIERNAN	2a. DATE KNOWN OF ESTI- MATED X 11/22/86	MONTH M	DAY 86	YEAR 1986	2b. HOUR 2d HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH May	DAY 15	YEAR 1902	6. AGE (IN YEARS LAST BIRTHDAY) 84 yrs.	IF UNDER 1 YR. MONTHS 	IF UNDER 24 HRS. DAYS 	HOURS 	MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Journalist			12b. KIND OF BUSINESS OR INDUSTRY Journalism		
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 11 South Walnut Street				
14. FATHER'S NAME FIRST Michael		MIDDLE 	LAST McKiernan	15. MOTHER'S MAIDEN NAME FIRST Sarah		MIDDLE 	LAST Stuart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 162-18-2571		17. INFORMANT William G. Cass		ADDRESS 102 Tree Top Court Timonium, MD, 21093		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #410 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 #188 CARCINOMA OF BLADDER, ADVANCED										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>George Milic</i>		TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER			DATE SIGNED 11/23/86					
EXAMINER'S NAME (TYPE OR PRINT) GEORGE MILIC, MD		ADDRESS 40 MANOR DR #103 HAGERSTOWN MD - 21740								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 28, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rocky Gap Cemetery		23d. LOCATION CITY OR TOWN Flintstone		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Minnich Funeral Home 415 East Wilson Blvd. Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 01 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Sander-Landree</i>						

6-5-20 221280

(6)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon from pages 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner or the attending physician must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 803310												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Mary Katherine MENTZER						11-24-86			7:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
female		white		July 20, 1904			82			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD		
Maryland		USA					Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County Hospital		housewife								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) GIVE RESIDENCE BEFORE ADMISSION												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Washington		Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1146 Luther Drive 21740		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
John Long		Lucy M. Hart										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no		217-28-6424		Lester M. Mentzer, Jr., Rohrersville, Md.						72 hrs		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a)												
Ventricular fibrillation												
DUE TO, OR AS A CONSEQUENCE OF (b) Autonomic hyperadrenergic Dysfunction 2 hrs												
Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Cardiac arrhythmic heart disease 4 yrs												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cardiovascular Shock												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-24-86 to 11-24-86, that (I) (we) last saw the deceased alive on 11-24-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						11-24-86				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE
burial		Nov. 26, 1986		Greenlawn Mem. Park			Williamsport, Wash., Maryland					
24. FUNERAL DIRECTOR		MINNICH FUNERAL HOME ADDRESS			25. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE			NOV 28 1986				
		415 E. Wilson Blvd., Hagerstown, Md. 21740										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation.

IMPORTANT: If item 21 is marked or item 23 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 3318							
DECEDENT'S NAME (TYPE OR PRINT)			Ruth H. MILLER		2a DATE OF DEATH 11-2-86	MONTH NOV	DAY 2	YEAR 1986	2b. HOUR 8 A M			
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH Dec. DAY 20, YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Williamsport, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		MD.			
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Schools					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12 Walnut St. 21740				
14. FATHER'S NAME FIRST Joseph MIDDLE E. LAST Downs					15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE				LAST Lesher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-38-9171		17. INFORMANT Mr. Daniel J. Miller, Jr.		ADDRESS 125 Holly Terrace Hagerstown, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					causes							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <u>widespread metastasis</u>		DUE TO, OR AS A CONSEQUENCE OF <u>widespread metastasis</u>				weeks			
			(c) <u>cholangiocarcinoma</u>		DUE TO, OR AS A CONSEQUENCE OF <u>cholangiocarcinoma</u>				6 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 2, 1986</u> , to <u>Nov 2, 1986</u> , that (I) (we) last saw the deceased alive on <u>Nov 2, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Harold R. Trutch Jr.</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11-3-86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Harold R. Trutch Jr.</i>		22e. ADDRESS <i>138 E. ANTETAM ST Hagerstown, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-4-86		23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery		23d. LOCATION CITY OR TOWN Boonsboro, Wash. Co., Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR Bast Funeral Home John H. Bast, Jr. Boonsboro, Md. 21713						25a. DATE REC'D. BY REGISTRAR NOV - 7 1986		25b. REGISTRAR'S SIGNATURE <i>Alia Leidman-Randee</i>				

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effort. This is the first time in history that we have had to do this.

It is a difficult task, but it is a task that must be done.

We must work together to make this happen.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 205666 DEC 23 1986												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Ethel L. Mills						Nov. 20, 1986						12:20 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Month Jan. Day 2, 1899 Year		87			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
Virginia		U.S.A.				Washington Co.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Clearview Nursing Home			Statistician			Federal Civil Service				
USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13. STREET ADDRESS						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
Maryland		Montgomery		Washington D.C.		4821 Earlston Dr. 99999						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Hartwell				Jones	Ellen			T.		Edwards		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
No			577-09-5194			Mrs. Lois Hoover			Waynesboro, PA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Alimentary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)												9 days many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>August 19, 1986</i> to <i>11/20/86</i> , 1986, that (I) (we) last saw the deceased alive on <i>11/18/86</i> , 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.												22c. DATE SIGNED
22b. SIGNATURE <i>Edson B. Moody</i>		22d. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			<i>11/20/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edson B. Moody		22e. ADDRESS College Road, Hagerstown, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/22/1986		23c. NAME OF CEMETERY OR CREMATORIAL Price's Church Cem.		23d. LOCATION CITY OR TOWN Waynesboro			COUNTY Franklin	STATE Penn.		
24. FUNERAL DIRECTOR NAME <i>John J. Beck</i>		ADDRESS 50 S. Broad St. Waynesboro, PA			25a. DATE REC'D. BY REGISTRAR NOV 25 1986			25b. REGISTRAR'S SIGNATURE <i>Susan Gardner Broder</i>				

022602-00-00



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trunk permit. Then please remove carbon copies. Boxes 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene or other authority. If item 15 states any injury or other traumatic event, the medical examiner may be notified of this.

IMPORTANT: If Item 21 is marked or Item 15 lists any injury or other traumatic event, the medical examiner may be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33108

1 - STATE REGISTRAR

1a. RELEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH MONTH DAY YEAR

2b. HOUR

Elma

S.

Moulton

November 18, 1986

11:34 p.m.

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR
Feb. 28, 1895

6. AGE (IN YEARS LAST BIRTHDAY)

91

IF UNDER 1 YEAR
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN.

YRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

DC

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8

MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10. CITY OR TOWN OF DEATH

Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

5617 Lamar Road

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Economist

12b. KIND OF BUSINESS OR INDUSTRY

U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Mont.

13c. CITY OR TOWN

Bethesda

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS / ZIP CODE

5617 Lamar Rd.

20816

14. FATHER'S NAME

FIRST

Hosea

MIDDLE

B.

LAST

Moulton

FIRST

Elma

MIDDLE

LAST

Saunders

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) WW I

16b. SOCIAL SECURITY NO.

219-42-3732

17. INFORMANT

Ruth L. Cannon Same as item # 13

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 wks

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma of Cecum

3 wks

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) /

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION

10/29/86

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Ca Colon

20a. AUTOPSY?

YES NO 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH

IF EITHER, NOTIFY MEDICAL EXAMINER

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY

AT HOME, STREET, FACTORY, OFFICE, FARM, ETC |

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from May 12, 1977, to Nov 18, 1986, that (I) (we) last
saw the deceased alive on Nov 7, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

G. Stuart Scott, M.D.

DEGREE

ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN

22c. DATE SIGNED

11/19/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

G. Stuart Scott, M.D.

22e. ADDRESS

19201 Montgomery Village Ave., Gaithersburg, MD 20879

23a. BURIAL, CREMATION, REMOVAL

SPECIFY

Burial

23b. DATE

11/21/86

23c. NAME OF CEMETERY OR CREMATORIUM

Glenwood Cemetery

23d. LOCATION

CITY OR TOWN COUNTY STATE

Wash., DC

24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.

5130 Wisconsin Ave., N.W. Washington, D.C. 20016

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

11/02/1986

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or embalming.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified or called.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 3 1 0

DECEASED NAME (TYPE OR PRINT)				FIRST RHADA	MIDDLE Myrtle	LAST MOORE	2a. DATE OF DEATH NOV 16 86	MONTH YEAR	DAY	YEAR	2b. HOUR 5:57 AM		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH Sept. DAY 27 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		YRS.		MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11 W. Baltimore St. 21740					
14. FATHER'S NAME FIRST Benjamin		MIDDLE		LAST Johnson		15. MOTHER'S MAIDEN NAME FIRST Cora		MIDDLE		LAST Needy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-12-1099A		17. INFORMANT Edwin Clark, Hagerstown, Md.		ADDRESS							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Respiratory failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		multiple pulmonary emboli						2 mo			
		(c)		Bilateral deep vein thrombosis						2 mo			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to 11-16 , 19 86 . that (I) (we) last saw the deceased alive on 11-16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Harold R. Hutch Jr.</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-19-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Harold R. Hutch</i>		22e. ADDRESS Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash.		COUNTY		STATE Maryland			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR NOV 21 1986		25b. REGISTRAR'S SIGNATURE <i>John J. Minnich</i>							

2025 RELEASE UNDER E.O. 14176

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025247 NOV 25 1986

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Enoch Enoch Luther Myers				2a. DATE OF DEATH MONTH DAY YEAR 11-16-86	2b. HOUR 7 PM
3. SEX male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 18 03	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 83 yrs	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Dsg. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian	
13a. STATE Md.		13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 309 N. Cannon Ave., 21740
14. FATHER'S NAME FIRST Unknown		MIDDLE -	LAST -	15. MOTHER'S MAIDEN NAME FIRST Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-26-7597A		17. INFORMANT ADDRESS Mr. Paul G. Price, Hagerstown, Md., 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, cardiovascular disease					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) STREET CITY OR TOWN COUNTY STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____ to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. J. Price		DEGREE		22c. DATE SIGNED 11/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAHEED MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 1610-Oak Hill Ave. HAGERSTOWN.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Nov. 17, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory	23d. LOCATION CITY OR TOWN Smithsburg, Wash., Md.	STATE
24. FUNERAL DIRECTOR NAME Dennis L. Davis		25a. DATE REC'D. BY REGISTRAR NOV 24 1986		25b. REGISTRAR'S SIGNATURE nia Johnson-Randace	
NAME Davis Funeral Home, Smithsburg, Md., 21783					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you as the burial-transit permit, then please mail it to the State Dept. of Health and Mental Hygiene prior to burial, casketing or cremation. If item 21 is marked or item 18 shows any injury, or other important information, the medical examiner must be notified at once.

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Office of the Director, National Institute of Justice

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 24 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
<i>CATHERINE Ellen NAVE</i>					<i>NAVE</i>	<i>November 16, 1986</i>						<i>3:50 PM</i>						
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH June DAY 5 YEAR 1927		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 59 DAYS 0			IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 3 MIN. 50						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON			MD.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home										
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 635 Washington Ave. 21740										
14. FATHER'S NAME FIRST Robert MIDDLE LAST Metz			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST 															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-20-2832			17. INFORMANT Alex E. XXX Nave (item 13 above)			ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Cardiopathy</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>			DAYS <i>112 years</i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Old myocardial infarct, lung & kidney failure</i>																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>Nov. 16, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										<i>1881 to Nov. 1986</i>								
22b. SIGNATURE <i>Gloria F. Pura</i>										DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED <i>11/17/86</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F. PURA			22e. ADDRESS 366 Mill St. Hagerstown															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 19, 1986		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		23d. LOCATION CITY OR TOWN Williamsport Washington Maryland		COUNTY		STATE								
24. FUNERAL DIRECTOR NAME Major M. Osborne			ADDRESS Williamsport, MD 21795			25a. DATE RECEIVED BY REGISTRAR NOV 20 1986		25b. REGISTRAR'S SIGNATURE <i>J. Osborne</i>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The

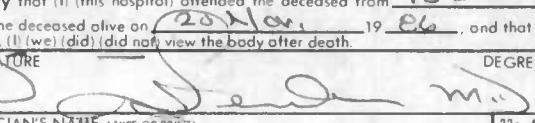
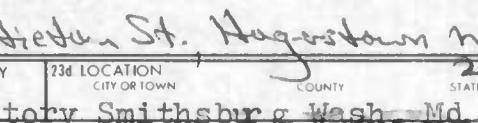
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the original signature and sign over the top of it with the State Dept. of Health and Mental Hygiene prior to burial/cremation. On pages 1 and 2 should be filed within 72 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 33172

1. DECEASED NAME (TYPE OR PRINT) Elizabeth			LAST OLDFIELD			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 26, 1986			2b. HOUR 7:30 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 6 1896	6. AGE (IN YEARS LAST BIRTHDAY) 90	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 23 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON Co., MD.								
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AVALON MANOR	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Writer	12b. KIND OF BUSINESS OR INDUSTRY Paper								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13c. CITY OR TOWN Montgomery Silver Spring			13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1911 East West Highway 20972				
14. FATHER'S NAME FIRST Albert			MIDDLE Franklin	LAST Wehle	15. MOTHER'S MAIDEN NAME FIRST Elizabeth	MIDDLE Marie	LAST Wood				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN Yes			16b. SOCIAL SECURITY NO. WW-I 578-09-9778			17. INFORMANT ADDRESS Medford, N.Y. 11763 Patricia Hohne 3114 Heather Avenue					
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a) Pneumonia, bilateral						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause first. (b)											
{ DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Arteriosclerosis generalized. Arteriosclerotic heart disease.											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 15 Jun. , 19 85 , to 26 Nov. , 19 86 , that (I) (we) last saw the deceased alive on 20 Nov. , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 			DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 26 Nov 1986				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Feuder			22e. ADDRESS 138 E Antietam St. Hagerstown MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 11-29-86	23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory Smithsburg Wash. Md.	23d. LOCATION CITY OR TOWN Smithsburg	COUNTY	STATE						
24. FUNERAL DIRECTOR NAME Gerald N. Minnich	DATE RECED. BY REGISTRAR JUL 03 1986	REGISTRAR'S SIGNATURE 									

DC-35-CASE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 50M 4/83
(VRA 15, 4)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												53193					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ruth	Edith						Otto			11/16/1986						2:50 P.M.	
3. SEX		4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White			July 6, 1892						94 yrs			MONTHS	DAYS	HOURS	MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA									Washington Co.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY						
Boonsboro		Fahrnley Keedy Home									Seamstress			Clothing			
13a. JURAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13b. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			219 E.Main St. 21782								
14. FATHER'S NAME FIRST John				15. MOTHER'S MAIDEN NAME FIRST Alice				16. LAST Miller									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. -----		17. INFORMANT		ADDRESS											
		219-20-1697		William Wyand (item 13 above)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____																	
DOUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <i>O. Waheed, M.D.</i>					
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22d. DATE SIGNED 11-17-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1610 Oak Hill Avenue Hagerstown, MD 21740															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 20, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery			23d. LOCATION CITY OR TOWN sharpsburg			COUNTY Washington		STATE Maryland					
24. FUNERAL DIRECTOR NAME Major M. Osborne		ADDRESS Williamsport, MD 21795			25a. DATE REC'D. BY REGISTRAR NOV 20 1986			25b. REGISTRAR'S SIGNATURE <i>John Randolph</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

Secured within 24 hours after death. Page 4 may be attached.

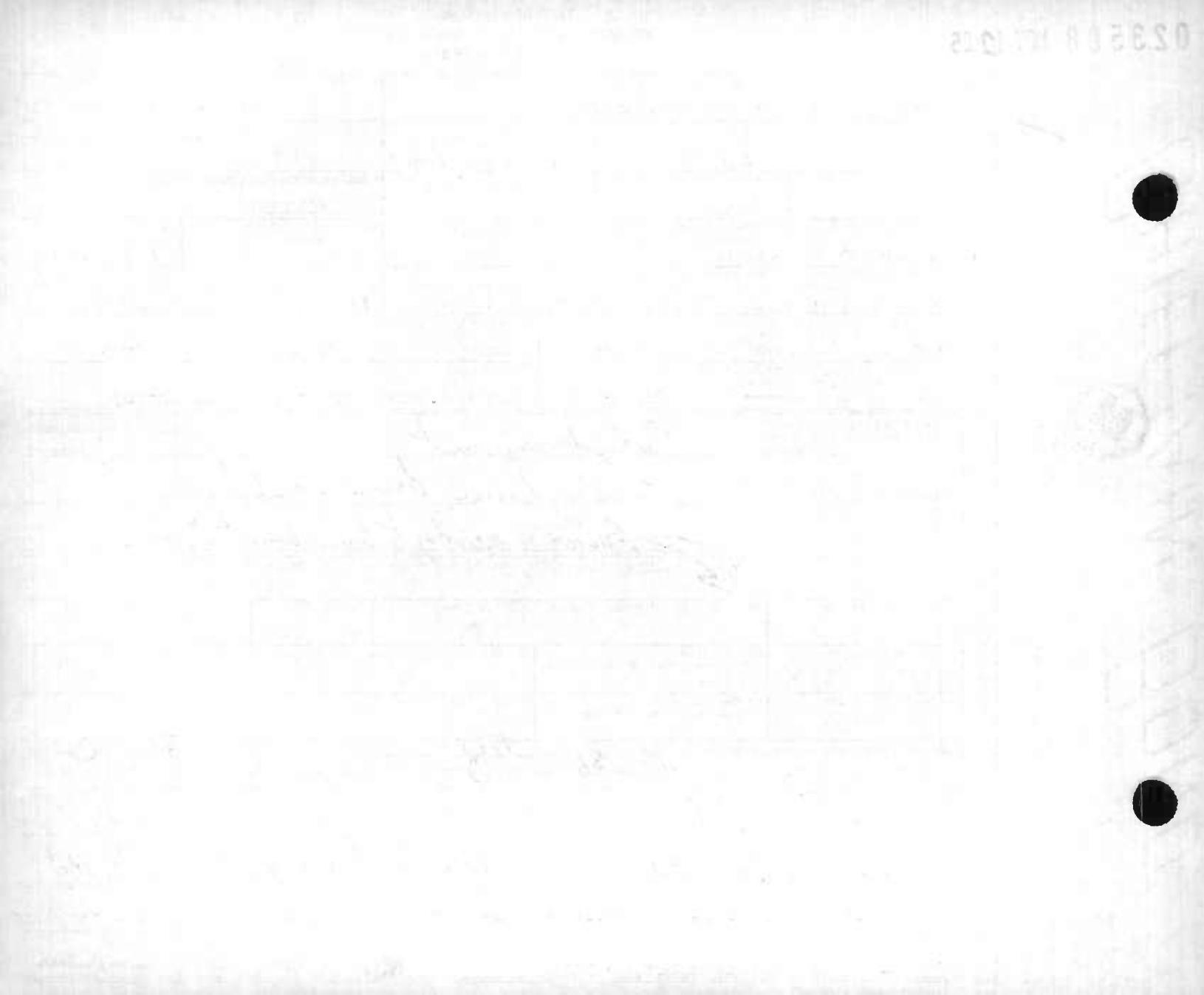
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked on purpose to show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33174						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
John Allen Otzelberger						11 - 2 - 86					201 PM					
3. SEX <i>m</i>			4 RACE <i>w</i>		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>WASHINGTON</i>			MD.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WCH</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Follett mfg.</i>								
13a. STATE <i>MD</i>			13b. COUNTY <i>Wash</i>		13c. CITY OR TOWN <i>Sharpsburg</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>Pt 1 Box 101 21782</i>					
14. FATHER'S NAME FIRST <i>Peter</i>			MIDDLE <i>Allen</i>	LAST <i>Otzelberger</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>			MIDDLE <i>Estella</i>			LAST <i>Gray</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>-----</i>		17. INFORMANT <i>Aleta A. Otzelberger (item 13 above)</i>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>					
18. CAUSE OF DEATH (Enter only one cause per line for Part I and II) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular disease: cerebral ischemia</i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Anesthesia secondary to severe dementia, chronic</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>1985</i>			CITY OR TOWN <i>11</i>			COUNTY <i>1985</i>		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>saw the deceased alive on 10 19 86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														22b. DATE SIGNED <i>11/3/86</i>		
22b. SIGNATURE <i>R.L. Kugler MD</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.L. Kugler MD</i>			22e. ADDRESS <i>100 Geeting Lane Keedysville, Md</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial			23b. DATE Nov. 5, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery			23d. LOCATION CITY OR TOWN <i>Sharpsburg</i>			COUNTY <i>Washington</i>		STATE <i>Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>MAJOR M. Osborne Williamsport, MD 21795</i>			25a. DATE REC'D. BY REGISTRAR NOV 10 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon dates from items 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, attach a separate sheet of paper and describe it in detail.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
FRANK J. PELC						11-8-86			11	8	86	7 09 P.M.	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 72 HRS	
Male			Caucasian	MONTH	DAY	YEAR	76 yrs			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania			U.S.A.						Washington County MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Washington County Hospital						Truck, Inc.				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Avalon Manor 21740					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Piotr				Pelc	Zofia				Drozo				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
no			144-07-7728			Mrs. Margaret Sanchez, Hagerstown, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Q. Sheal</i>										DEGREE	22c. DATE SIGNED 11/8/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
ABDUL WAHEED, MD			1610-Oak Hill Ave. HAGERSTOWN, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
burial			Nov. 12, 1986	Rest Haven Cemetery			Hagerstown, Wash., Maryland						
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740			NOV 17 1986			<i>Julia Davis</i>							

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Population Growth

Population Growth



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if it may be

retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than a natural death, send the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Alice L. Poffenberger						11-19-86				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. H
Female		White		MONTH DAY YEAR May 7, 1922		64		MONTHS DAYS		M
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		USA				Washington		Washington		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		643 Pennsylvania Ave.		homemaker		home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/>		643 Pennsylvania Ave.		21740
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Owen		Edward		Poffenberger	Bertha		Elizabeth		Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no				Isabell I. Watkins		513 S. Potomac Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____										
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.										Acute CVA
DUE TO, OR AS A CONSEQUENCE OF (c) _____ Generalized arteriosclerosis										immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		1933 Va. Ave, Hagerstown, Md						05-21-86
23a. BURIAL, CREMATION, REMOVAL SPECIFY: Burial		23b. DATE 11-22-86		23c. NAME OF CEMETERY OR CREMATORIAL Keedysville Cemetery		23d. LOCATION CITY OR TOWN Keedysville		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME: Gerald N. Minnich ADDRESS: 305 N. Potomac St. Hagerstown, Maryland										REGISTRATION NUMBER 01-1986

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The certificate, carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 86 33197								
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
Florence Elizabeth PRICE									November 30, 1986		5:00 a.m.		
1. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8 CITIZEN OF WHAT COUNTRY?		9 BALTIMORE CITY OR COUNTY OF DEATH	
female		white		June 13, 1890		96 yrs.		West Virginia		U.S.A.		Washington MD.	
7b. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		111 East Wilson Blvd.		housewife									
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 111 East Wilson Blvd. 21740				
14. FATHER'S NAME FIRST Charles			MIDDLE L.		LAST Flynn		15. MOTHER'S MAIDEN NAME FIRST Ida		MIDDLE E.		LAST Ward		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
no					Mrs. Catherine V. Davis, Hagerstown, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Congestive and Forward output Heart Failure												2 months	
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Coronary heart Disease												10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/19/86 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.												22b. SIGNATURE Robert Brull	
22c. DATE SIGNED 12/1/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull		22e. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE burial Dec. 3, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland		23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 East Wilson Blvd., Hagerstown, Maryland 21740		25a. DATE REC'D. BY REGISTRAR DEC 3 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

2025 RELEASE UNDER E.O. 14176

DISASTER RELIEF
WORLD BANK

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal to show any injury, or other trauma.

IMPORTANT: If Item 21 is marked show the medical examiner if he wishes to examine the deceased.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33190					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
<i>IRENE</i>			<i>M</i>				<i>RAGLAND</i>		<i>NOVEMBER 18 1986</i>					<i>855 P M</i>	
3. SEX female			4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 101 S. Potomac St. 21740		12b. KIND OF BUSINESS OR INDUSTRY restaurant				
14. FATHER'S NAME FIRST Charles			MIDDLE Ellis		LAST Morris		15. MOTHER'S MAIDEN NAME FIRST Flora May		MIDDLE		LAST Smith(Warrenfeltz)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 18a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 years				
18b. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)												
18c. DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/18 86 , to 11/18 86 , 19_____, that (I) (we) last saw the deceased alive on 11/18 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) view the body after death.															
22b. SIGNATURE <i>L. Flanagan</i>			22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/19 86								
22e. PHYSICIAN'S NAME (TYPE OR PRINT)															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Nov. 22, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland								
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR NOV 24 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Minnich-Randace</i>										

525L 811123



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8 8 3 3 1 9 7											
1. FOR REGISTRAR: JOSEPH ALLEN RAYMER			2a. DATE OF DEATH MONTH DAY YEAR 11 10 86								
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. HOUR 6:40 P.M.					
JOSEPH ARTHUR RAYMER											
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 6 DAY 14 YEAR 1910			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Electric Co.		
13a. STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 1822 Jefferson Blvd. 21740											
14. FATHER'S NAME FIRST David MIDDLE Homer LAST Raymer			15. MOTHER'S MAIDEN NAME FIRST Sadie MIDDLE Leloa LAST Langdon								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-09-5332			17. INFORMANT Mildred D. Raymer			18. ADDRESS 1822 Jefferson Blvd. Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strong 11/10/86 Acute congestive heart failure pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ruptured abdominal aortic aneurysm</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH " "											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 11/10/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ruptured abdominal aorta</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/10 19 86 to 11/10 19 86, that (I) (we) last saw the deceased alive on 11/10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John R. Marsh, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/10/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN R. MARSH, M.D.</i>			22e. ADDRESS 239 N. Potomac St. HAGERSTOWN, MD. 21740								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-13-86			23c. NAME OF CEMETERY OR CREMATORIAL St. Pauls Lutheran Cem.			23d. LOCATION CITY OR TOWN Myersville, Frederick, Md.		
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 14 1986			25b. REGISTRAR'S SIGNATURE <i>John R. Marsh, M.D.</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial emblem. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Charles</i>	MIDDLE <i>M</i>	LAST <i>Ripple</i>	REG. NO.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 20 YEAR 1909			2a. DATE OF DEATH MONTH 11 DAY 16 YEAR 86	2b. HOUR 4:40 AM		
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN. 0						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenace			12b. KIND OF BUSINESS OR INDUSTRY Frick Co.			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 109 Elm Street 21740		
14. FATHER'S NAME FIRST Charles		MIDDLE Franklin	LAST Ripple	15. MOTHER'S MAIDEN NAME FIRST Lulu		MIDDLE Louise	LAST Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-0523		17. INFORMANT Donna M. Bentz same as 13			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>				
DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u>						<u>few hours</u>				
DOUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>						<u>few hours</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ABCD</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-15-86</u> , 19 <u>86</u> , to <u>11-16-86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11-15-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Vasant Datta</i>		DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11-16-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, MD		22e. ADDRESS 115 W. WASH. ST HAGERSTOWN, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-17-86		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION CITY OR TOWN Smithsburg Wash. Md.		STATE MD		
24. FUNERAL DIRECTOR <i>Gerald N. Minnich</i>		ADDR. 305 N. Potomac St. Hagerstown, Maryland			25a. DATE REC'D. BY REGISTRAR NOV 24 1986			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

ANSWER

TO HOSPITAL OR ATTENDING PHYSICIAN) The
certified by the hospital or attending physician

NOTE: The requirements that the cloth centrifuge be measured within 24 hours after death. Page 4 may be

MEDICAL CERTIFICATION

NOV 13 1986 FOR
STATE REGISTRATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REF NO

I. DECEASED NAME (TYPE OR PRINT)			FIRST Carl	MIDDLE Edward	LAST RUDY	2a DATE OF DEATH MONTH DAY YEAR November 13, 1986	2b HOUR MD
3. SEX <input checked="" type="checkbox"/> male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR June 16, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD				
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed			12b. KIND OF BUSINESS OR INDUSTRY market		
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11 W. Baltimore St. 21740			
14. FATHER'S NAME FIRST Jerome H. Rudy	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Lula L. Poffenberger			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-9837	17. INFORMANT ADDRESS Nellie Ahalt, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Respiratory Failure</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>G. Wheeler</i>			DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/13/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABDUL WAHABED M.D.</i>			22e. ADDRESS 1610 - OAK HILL AVE. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Nov. 17, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland	23e. DATE REC'D. BY REGISTRAR NOV 17 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Readhead</i>
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740	MINNICH FUNERAL HOME ADDRESS			25a. DATE REC'D. BY REGISTRAR			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Begin page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove cover page. Then place removal coupon in the burial permit. Then place removal coupon in the burial permit with the State Dept. of Health and Mental Hygiene prior to Burial; cremation with the State Dept. of Health and Mental Hygiene prior to Burial; or any injury, or other trauma.

IMPORTANT: If item 21 is marked or if item 18 is checked

33202

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR				
LEONARD			---		SCHLOSSER	11/12/86				8:30 A.M.				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)											
MALE	White	MONTH DAY YEAR	84	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		MD.									
Monroe, Md.	U. S. A.	Washington												
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY											
Boonsboro	REEDERS MEMORIAL HOME	Farmer	Farmer											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE										
Maryland	Washington	Boonsboro	YES <input checked="" type="checkbox"/>	20 Potomac St. 21713										
14. FATHER'S NAME	FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME												
E. Thomas Schlosser	Bessie Murray													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. ADDRESS											
No	220-34-2209	Mr. James E. Shifler, Box 188	Rfd. 4	Boonsboro, Md. 21713										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden death - cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF <i>ASCVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF <i>CAD cerebrovascular disease</i> (c) _____														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. _____														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED <i>while at work</i> <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>11/12/86</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		19 11/12/86 to 19 11/12/86												
22b. SIGNATURE		DEGREE			22c. DATE SIGNED									
R. L. KUGLER, M.D., P.C.					ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	11/12/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
P. O. BOX 246 KEEDYSVILLE, MD 21756														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-15-86	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery			23d. LOCATION Boonsboro, Wash. Co., Md.								
24. FUNERAL DIRECTOR John H. Bast, Jr.		ADDRESS Boonsboro, Md. 21713	25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
			NOV 17 1986			<i>Julia Scidmore, Landes</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please return to the medical examiner. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other significant event in the medical examiner's report, notify the medical examiner.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33205			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ella	MIDDLE Mae	LAST Shives	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 9 06 4 M			
3. SEX F			4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07 18 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS				IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE COUNTRY PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON				MD.		
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION 12b. KIND OF BUSINESS OR INDUSTRY Cook DORMATORY								
13a. STATE MD			13b. COUNTY WASHINGTON		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1725 WABASH AVE 21740				
14. FATHER'S NAME FIRST William P			MIDDLE YANKER	LAST	15. MOTHER'S MAIDEN NAME FIRST Rhoda				MIDDLE Belle	LAST Gordon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-40-2989		17. INFORMANT ADDRESS BETTY J. WALTZ				HCR 80 Box 114 BIG COVE TANNERY PA.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/27/86			
22b. SIGNATURE QSP										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAITER MD			22e. ADDRESS 1610 OAK HILL AVE. HAGERSTOWN, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/30/86		23c. NAME OF CEMETERY OR CREMATORIAL SHIVES CEMETERY		23d. LOCATION CITY OR TOWN Hancock Wash. MD.						
24. FUNERAL DIRECTOR NAME Julia Dawson-Randall			ADDRESS Hancock Grove Hancock MD.		25a. DATE REC'D. BY REGISTRAR DEC 3 1986				25b. REGISTRAR'S SIGNATURE Julia Dawson-Randall				

574.13 506 63

100% of the time

Presentation: Bright yellow-green, translucent

Smooth surface, no wrinkles or irregularities. Color bright
yellow-green with some yellowish-green mottling. Size 2.5 cm
in all directions with a thin, smooth, shiny surface.Smooth surface, no wrinkles or irregularities. Color bright
yellow-green with some yellowish-green mottling. Size 2.5 cm
in all directions with a thin, smooth, shiny surface.

Smooth surface, no wrinkles or irregularities. Color bright

yellow-green with some yellowish-green mottling. Size 2.5 cm

in all directions with a thin, smooth, shiny surface.

Smooth surface, no wrinkles or irregularities. Color bright

yellow-green with some yellowish-green mottling. Size 2.5 cm

in all directions with a thin, smooth, shiny surface.

Smooth surface, no wrinkles or irregularities. Color bright

yellow-green with some yellowish-green mottling. Size 2.5 cm

in all directions with a thin, smooth, shiny surface.

Smooth surface, no wrinkles or irregularities. Color bright

yellow-green with some yellowish-green mottling. Size 2.5 cm

in all directions with a thin, smooth, shiny surface.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and forwarded to you, it should be detached from us or the burial-transit permit. Then please remove carbon paper. Page 4 may be retained by you and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33204						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Charlotte M				Mae	Sister	11			17	86		M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR			72 YRS.			MONTHS DAYS		HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MD			USA			7 - 15 - 14			Washington							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown			Washington Co. Hospital									shoe company				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
MD			Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1004 1/2 Salem Ave 21740						
14. FATHER'S NAME FIRST			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME										
Harry			John William		Renner	Lillian			Mae			Deatrich				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no			212-24-5562			Debbie Wynkoop, Hagerstown, Md.						days.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Renal failure						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
Carcinoma, (R) Colon with massive hepatic metastases.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
11-13-86			Carcinoma, (R) colon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-8-86 19, to 11-17 1986, that (I) (we) lost saw the deceased alive on 11-17 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
Est Hawbush									11-17-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
burial																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE				
burial			Nov. 19, 1986			Rest Haven Cemetery			Hagerstown, Wash., Maryland							
24. FUNERAL DIRECTOR NAME			MINNICH FUNERAL HOME ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
415 E. Wilson Blvd., Hagerstown, Md. 21740						NOV 19 1986										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FOR
STATE
REGISTRAR
*NOV 18 1986*STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO.
3320

1. DECEASED NAME (TYPE OR PRINT)	FIRST Gladys	MIDDLE Ellen	LAST SMETZER	2a. DATE OF DEATH MONTH DAY YEAR Dec. 28, 1910	MONTH YEAR 11 - 6 - 86	DAY YEAR 105 A.M.	2b. HOUR 105 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 24 HRS MONTHS 75 YRS	IF UNDER 24 HRS DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria Worker	12b. KIND OF BUSINESS OR INDUSTRY School		
13a. STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Smithsburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 71A 21783			
14. FATHER'S NAME FIRST John	MIDDLE W.	LAST Cline	15. MOTHER'S MAIDEN NAME FIRST Mae	MIDDLE T.	LAST Hauver		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - 220-05-6443	17. INFORMANT Mrs. May E. Wolfe, Smithsburg, Md., 21783	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Perforation of small bowel</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks.	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Non-Hodgkin's malignant lymphoma.</i>						1 year.	
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Arterosclerotic cardiovascular disease.</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) saw the deceased alive on Nov 5 1986 and that in my opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE	
22a. I certify that (if this hospital) attended the deceased from Aug 20 1985 to Nov 6 1986, that (if not last seen, the deceased alive on Nov 5 1986 and that in my opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)							
22b. SIGNATURE <i>Richard E. Smith, M.D.</i>	DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/6/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.	22e. ADDRESS 1708 Oak Hill Ave, Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 9, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery	23d. LOCATION Smithsburg, Wash., Md.				
24. FUNERAL DIRECTOR <i>Davis Funeral Home</i>	25a. REG. DAILY REC'D. CARTRIDGE NOV 12 1986			25b. REGISTRAR'S SIGNATURE <i>Jules Sander-Landis</i>			
BP _____							

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Fig. 2. - *Pyrrhocoris apterus* L.

Lithocase versus lithopane

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attorney for the deceased, it should be detached for use as the burial-trust permit. Then please remove the signature of the physician and sign the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic death, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 803320			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Grace</i>	MIDDLE <i>Kriete</i>	LAST <i>Smead</i>	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
						MONTH <i>October</i>	DAY <i>2</i>	YEAR <i>1894</i>	11 9 86	03 1 PM			
3. SEX female			4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS					
					MONTH <i>October</i>	DAY <i>2</i>	YEAR <i>1894</i>	92	IF UNDER 1 YEAR MONTHS DAYS				
7a. BIRTHPLACE COUNTRY <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1134 Oak Hill Avenue</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>1134 Oak Hill Ave. 21740</i>					
14. FATHER'S NAME FIRST <i>Howard</i>			MIDDLE <i></i>	LAST <i>Kriete</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Nora</i>			MIDDLE <i>M.</i>	LAST <i>Hughes</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-10-2610D</i>			17. INFORMANT <i>Edwin H. Smead, Jr., Hagerstown, Md.</i>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Mild organic brain syndrome, hypertension, grand mal epilepsy</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>3129</i>			CITY OR TOWN <i>149</i>	COUNTY <i>1986</i>	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>10/16</i> , 19 <i>86</i> , to <i>10/16</i> , 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.										22c. DATE SIGNED <i>11/10/86</i>			
22b. SIGNATURE <i>Allen G. Kriete</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allan G. Kriete</i>			22e. ADDRESS <i>1134 Oak Hill Ave Hagerstown MD 21740</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE <i>Nov. 12, 1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN <i>Lorraine Park Cemetery Baltimore,</i>			23d. LOCATION CITY OR TOWN <i>Baltimore</i>				
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>			24a. DATE REC'D. BY REGISTRAR <i>NOV 17 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Deidre Landee</i>			25a. ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and witnessed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. For use as the burial/transit permit, attach this to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked Death, Item 19 shows only injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 33207				
										REG. NO.				
1 - STATE REGISTRAR			DECESSED NAME FIRST MIDDLE LAST			2d DATE OF DEATH MONTH DAY YEAR			2b HOUR					
[TYPE OR PRINT]			Arthur L. SNIDER			November 4, 86			12 ⁴⁵ AM					
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS					
Male		White		November 23, 1910			75		IF UNDER 24 HRS HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Penns		U.S.A.						Washington county MD.						
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Hagerstown		Avalon Manor Nursing Home			Laborer			Construction						
13a STATE Penns		13b COUNTY Franklin		13c CITY OR TOWN Greencastle		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 33 Edwards Drive 17225		99999				
14 MOTHER'S NAME FIRST Clarence		MIDDLE		LAST Snider		15. MOTHER'S MAIDEN NAME Elizabeth		MIDDLE		LAST Elliott				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		186-03-0475		Margaret Snider, 33 Edwards Drive Greencastle				48 hrs						
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia														
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Infected Foot Alzheimer's														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE WW Lesh MD		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
22d PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh md		22e ADDRESS 411 Division Ave Hagerstown, Md												
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-6-1986		23c. NAME OF CEMETERY OR CREMATORIAL Montgomery Church Cemetery, Montgomery Twp Franklin Penn			23d LOCATION CITY OR TOWN		COUNTY		STATE			
24 FUNERAL DIRECTOR NAME H. Martin Zimmerman		ADDRESS Greencastle, Pa			25a. DATE REC'D. BY REGISTRAR Nov 14 1986			25b. REGISTRAR'S SIGNATURE Julie Zimmerman i						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed within 24 hours after death, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon paper. Page 4 may be retained by the funeral director and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 28 shows any injury, or other traumatic event, the medical certification must be marked.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR JULIA ETHEL SPANGLER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 303209

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR	2b. HOUR IF UNDER 24 HRS HOURS MIN
Julia ETHEL SPANGLER					11-13-86	9:50 AM
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS
FEMALE		White		JAN. 21, 13		73 YRS.
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND		USA				Washington County MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN		CLEARVIEW NURSING Home		Housewife		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
MD		Washington		HAGERSTOWN		13e. STREET ADDRESS / ZIP CODE 54 EAST IRVIN AVE 21740
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula ALDA HARTLE
Frederick		William		Browne		ADDRESS 54 East Irvin Avenue Hagerstown, Md.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
NO		214-09-8021		John H. Spangler		2 days
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>anual Thrombocytopenia</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Alzheimer's Disease, arteriosclerotic heart disease, hypertension, dementia</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/21/86</u> to <u>11/13/86</u> , that (I) (we) last saw the deceased alive on <u>11/4/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Edison B. Moody M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/16/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edison B. Moody M.D.		22e. ADDRESS College Road, Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-15-86		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md. COUNTY STATE
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 19 1986		25b. REGISTRAR'S SIGNATURE <u>James D. Coffman, Jr.</u>

SAB12 12/2008

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3320

**1 - FOR
STATE
REGISTRAR**

~~DECEASED NAME~~
(TYPE OR PRINT)

5100

13 of 15

111-112

REG. NO

025388 NOV

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 5 TO THE FUNERAL DIRECTOR.

TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5. RETAIN PAGE 5 FOR YOUR FILES.

AFTER DEATH, WITH THE EXCEPTION OF BURIAL OR CREMATION, THIS CERTIFICATE SHOULD BE HELD UNTIL 24 HOURS.

BALTIMORE, MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF CORONERS
RECORDED 201 W. PRISTON STREET

DECEDENT'S NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Lisa Ann Staubs						X				a	
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	White	11/15/69	17 yrs.			November 19,	1986			2:30 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED XX WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA						Washington County, MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Sharpsburg		Burnside Bridge			Student			School			
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	21782				
Maryland		Maryland	Washington	Sharpsburg		Route 2, Box 244 (Dargan)					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS			
Edward Franklin Staubs		Cathrynn May Giffin			No			Route 2, Box 244 Edward F. Staubs - Sharpsburg, Md. 21782			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8159 IMMEDIATE CAUSE (a) Motor vehicle fixed object collision (E-815) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) penetrating wound through the abdomen from guard rail of bridge							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Howard N. Weeks</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D. ADDRESS 580 Northern Ave., Hag. Md. 21740 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 11/22/86 23c. NAME OF CEMETERY OR CREMATORIAL Samples Manor Cem. 23d. LOCATION CITY OR TOWN Samples Manor, Wash., Md. COUNTY STATE											
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert L. Spencer - Harpers Ferry, WV 25425		Drawer C			NOV 26 1986			<i>Juia Davidson-Randall</i>			

2020 RELEASE UNDER E.O. 14176



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the medical examiner, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 3 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 33210				
1. DECEASED NAME (TYPE OR PRINT)				FIRST: Horace	MIDDLE:	LAST: Sturm	2a. DATE OF DEATH			MONTH: 10	DAY: 29	YEAR: 86	2b. HOUR 5 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M		W		MONTH: 5	DAY: 5	YEAR: 13	73			MONTHS: YRS	DAYS:	HOURS: 5	MIN: A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
W. Virginia		U.S.								Washington County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Boonsboro		Route 3, Box 109 (Wash. Cty. Hosp.)		Manager						Greenhouse				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Md.		Washington		Boonsboro			YES <input type="checkbox"/> NO <input type="checkbox"/>			Route 3, Box 109 21713				
14. FATHER'S NAME		FIRST: Felix L.	MIDDLE: Sturm	LAST:	15. MOTHER'S MAIDEN NAME			FIRST: Duhamma	MIDDLE: Ellen	LAST: Radford	ADDRESS: Rt. 3, Box 108			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Mrs. Ellen M. Dorosh			Boonsboro, Md.				
No														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
Sudden death														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease Sudden														
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic hypoxemia, severe emphysema														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rheumatoid arthritis														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/28 1986 to 10/29 1986, that in (my) our opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.														
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
R.L. Kugler					Geeting Lane Keedysville, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Removal		10-29-86												
24. FUNERAL DIRECTOR NAME		ADDRESS			NOV 05 1986			25. REGISTRAR'S SIGNATURE						
Anatomy Board		Balto., Md.												

007-111 SP1630

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the medical examiner, it should be retained for 1 year. Then please remove carbon paper. Please return to the State Dept. of Health and Mental Hygiene prior to Burial, Cremation, or removal.

IMPORTANT: If Item 21 is marked as being a "show cause injury", or after traumatic event, the medical examiner will be notified by the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										33211	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)	Archibald <u>ARCHIE</u>			MIDDLE NMN	LAST STEVENS	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.		
male	white	MONTH DAY YEAR July 21, 1909			77	MONTHS DAYS			HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania	USA						Washington				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown	Colton Villa Nursing Center			horse groomer			racetrack				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										MD.	
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 334 Jefferson St. 21740					
14. FATHER'S NAME FIRST Theodore	MIDDLE	LAST Stevens, Sr.	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE E.	LAST McAllister				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. W.W.II	16c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	17. INFORMANT Haviland Griffith, Hagerstown, Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
yes	217-09-5043	Cardiac arrest									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease											
c) DUE TO, OR AS A CONSEQUENCE OF Diabetes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 11/13/88	
22b. SIGNATURE <u>Q.R. Paine</u> DEGREE											
22c. ADDRESS 1610- OAK Hill Ave. HAGERSTOWN, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Nov. 15, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Wash., Maryland	STATE					
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REG'D. BY REGISTRAR NOV 18 1986			25b. REGISTRAR'S SIGNATURE							

2011 RELEASE UNDER E.O. 14176

WHITE
HORN



WILDLIFE CONSERVATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 36 33212				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Sabrina A. Stup					STUP	11 14			86			11:10 PM		
3. SEX Female			4 RACE White		5. DATE OF BIRTH MONTH June 5, 1959 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 27			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County			MD.			
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Employed			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 902 Mercer Place 21701						
14. FATHER'S NAME FIRST W.			MIDDLE Wilson	LAST Stup	15. MOTHER'S MAIDEN NAME Frances			16. SOCIAL SECURITY NO. 212-88-8608			17. INFORMANT ADDRESS W. Wilson Stup 902 Mercer Place Frederick, Md. 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DEHYDRATION			DUE TO, OR AS A CONSEQUENCE OF SHOCK											
(c) DUE TO, OR AS A CONSEQUENCE OF SHOCK			12 HOURS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PROFOUND MENTAL RETARDATION SEIZURE DISORDER														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>SPRING</u> 19 <u>86</u> , to <u>11-14</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE M. Douglas Becker MD			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 11-15-86								
22e. ADDRESS 138 E. ANTIETAM ST HA GERSTOWN MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 19, 1986 Mt. Olivet Cemetery			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN Frederick, Frederick, Md.			23d. LOCATION CITY OR TOWN Frederick, Frederick, Md.					
24. FUNERAL DIRECTOR NAME Smith, Keeney & Basford Funeral Home 106 East Church St., Frederick, Md. 21701			25a. DATE REC'D. BY REGISTRAR NOV 19 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Purcell								

Item #18a, G-623, med. Ex; 11/17/86 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "WORK PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 SHOULD BE FILED FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FILED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.		
Melvin Lee Taylor						46 33210		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2a. DATE KNOWN OF ESTI- DEATH MATED		
Male	White	Feb. 2, 1929	57 yrs.			11-17-86		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		2c. DATE PRONOUNCED DEAD		
Maryland		U.S.A.				11-17-86		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Pk.		Washington Co. Hospital				Presser	Leather	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Washington	Williamsport			117 N. Conococheague St.	21795	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Roman Edward Taylor			Mary Naomi Salsgiver					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		12. ADDRESS		
yes		Korea 220-26-5822		Ronnie Taylor		12 S. Conococheague St. 21795		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <i>Carcinoma of tongue with absence of mouth with osteomyelitis of the formation</i> PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>absence of mouth with osteomyelitis of the formation</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <i>loss of tongue</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		<i>Maryann Korell</i> TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.				DATE SIGNED 11-20-86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		
Burial		November 21, 1986		Greenlawn Memorial Park		County State Williamsport Washington Maryland		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Major M. Osborne		Williamsport, MD 21795		NOV 24 1986		Julia David Readhead		



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												332					
FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Paul HENRY Thomas						Thomas			11 7 86						10 ²⁶ AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE			CAUCASIAN			MONTH 4 DAY 17 YEAR 04			82			MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WASHINGTON								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Hagerstown			Washington County Hospital									Farmer					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Washington			Hagerstown						1112 Luther Dr. 21740					
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			12b. KIND OF BUSINESS OR INDUSTRY					
Howard			Bertrude			Thomas			Minnie			Agriculture					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no			-----			716-03-2102			Ruth F. Thomas (item 13 above)			20 minutes					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiac arrest</u>																	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ruptured aortic aneurysm</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 hours</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
11/7/86			<u>aortic</u> <u>ruptured aneurysm</u>									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			HOUR A.M. MONTH DAY YEAR P.M. 19														
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7/78</u> to <u>11/7/86</u> , that (I) (we) last saw the deceased alive on <u>11/7/78</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
STEPHEN M. SACHS															11/7/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23d. LOCATION CITY OR TOWN											
STEPHEN M. SACHS			239 N. Potomac St, Hagerstown			COUNTY											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE					
Burial			Nov. 11, 1986			Greenlawn Memorial Park			Williamsport			Washington Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Major M. Osborne			Williamsport, MD 21795			NOV 14 1986			via facsimile								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

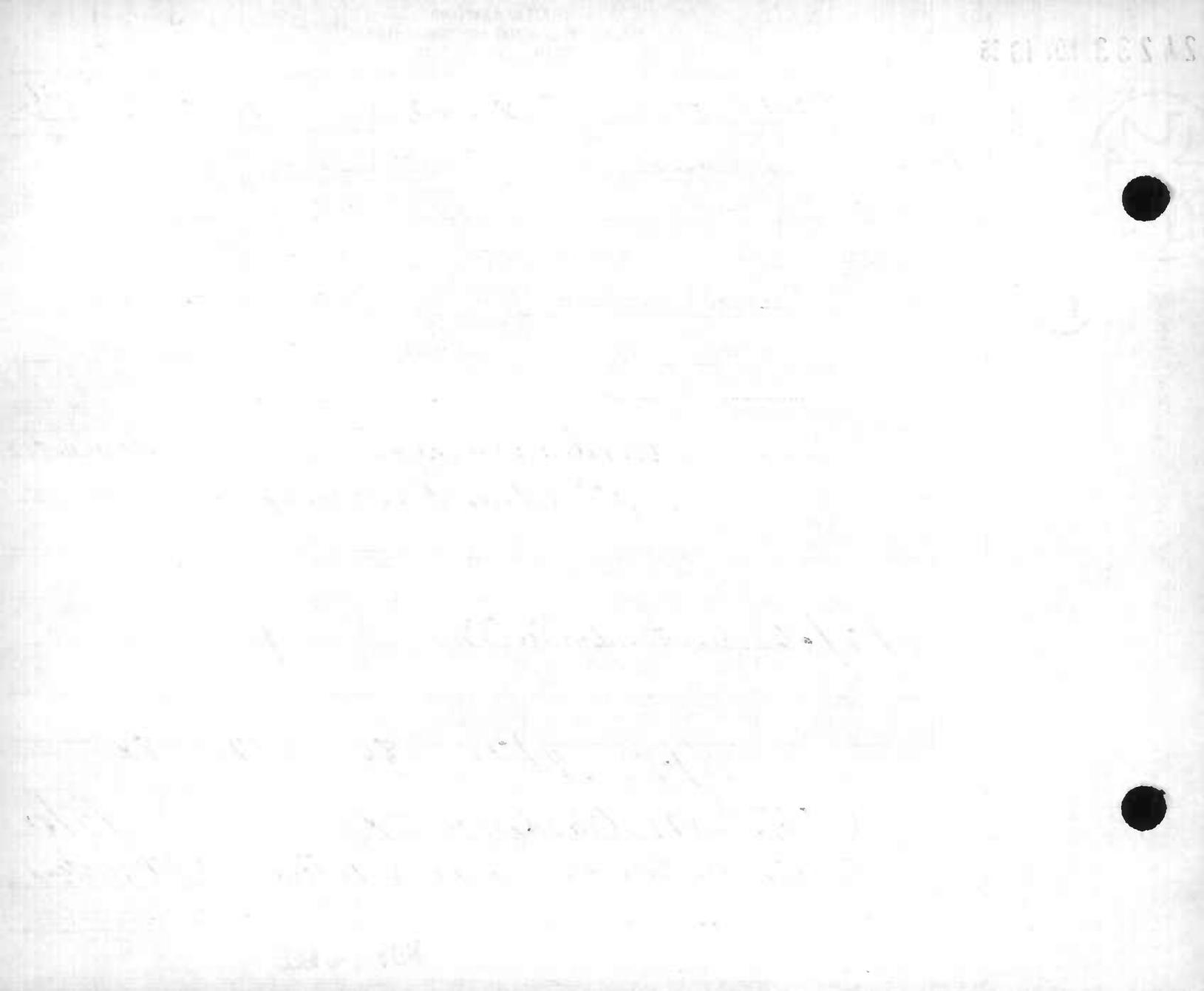
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please return carbon paper. Page 1 and 2 may be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, this medical statement must be included in the certificate.

BP _____

DHMH - 1650M 1/76
(VR A 15 (4))

RECORRIDOS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner may be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH November 20, 1986			2b. HOUR 6:20AM		
Mary			Viola	Tosten		6 AGE (IN YEARS LAST BIRTHDAY)	89	IF UNDER 1 YEAR MONTHS DAYS	M IF UNDER 24 HRS HOURS MIN.		
3. SEX Female			4 RACE White		5. DATE OF BIRTH September 6, 1897					YRS.	
7a. BIRTHPLACE COUNTRY Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington			MD.	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Coffman Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1020 Main Ave. Hag. Md. 21740		
14. FATHER'S NAME FIRST Franklin			MIDDLE	LAST Atherton	15. MOTHER'S MAIDEN NAME FIRST Alice			MIDDLE	LAST Rasp		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no		17. INFORMANT Olca King			ADDRESS 1020 Main Ave. Hag. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic obstructive pulmonary disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>year</i>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Cardiac arrhythmia; Senility</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) _____						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____						
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 20, 1986</i> , to <i>Nov 20, 1986</i> , that (I) (we) last saw the deceased alive on <i>Nov 20, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED <i>11/21/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <i>145 W. Washington St</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>					
<i>L L Packer Jr MD</i>			<i>145 W. Washington St</i>			<i>145 W. Washington St</i>			<i>11/21/86</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 23, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Welsh Run Cem.			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____			
24. FUNERAL HOME NAME MANICH Funeral Home 415 East Wilson Boulevard			ADDRESS Hag. MD		25a. DATE REC'D. BY REGISTRAR NOV 28 1986			25b. REGISTRAR'S SIGNATURE <i>J. Daibon-Landess</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper from the back of the certificate and mail it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked **YES**, show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Greensbury Townsend			November 21, 1986			0620 M
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Black	Jan. 12 1921		65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.A.			Wicomico	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salisbury		Peninsula General Hospital				Labor
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Wicomico	Fruitland		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME		MIDDLE LAST	ADDRESS
Emory		Townsend	Daisy		Beverly	405
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes		WWII	Norman Cottman		Fruitland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding death						
DUE TO, OR AS A CONSEQUENCE OF (b) Massive transfusion						
DUE TO, OR AS A CONSEQUENCE OF (c) Severe hemorrhagic gastritis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Severe Corrosive, Gastric Ulcers, Bleeding						
19a. DATE OF OPERATION 11/20/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemorrhage gastritis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 11/19/86 to 11/21/86, that (I) (we) lost saw the deceased alive on 11/21/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE C. G. Cottman		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. G. Cottman		22e. ADDRESS H. B.ity Rans Prof. Cottman, Salisbury				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-25-86	23c. NAME OF CEMETERY OR CREMATORIAL West P.O. St. Marys		23d. LOCATION CITY OR TOWN West P.O. S	COUNTY STATE Md.
24. FUNERAL DIRECTOR NAME Wm. H. James III		ADDRESS P. O. Box Anne Md	25a. DATE REC'D. BY REGISTRAR DEC 2 1986		25b. REGISTRAR'S SIGNATURE T. C. C. Cottman	

052001 NO-30

B E L O N G S T O

Mr. John V. Dool \$330

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER LONG WITH FOR PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3321		
1. DECEDENT'S NAME (TYPE OR PRINT)			FIRST JAMES	MIDDLE O.	LAST TRUMPPOWER	2a. DATE KNOWN OF EST. DEATH MATED			<input checked="" type="checkbox"/> MONTH Nov. 21 1986	DAY 1986	YEAR 1986	2d HOUR 4:53 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 4, 1929	6. AGE (IN YEARS LAST BIRTHDAY) 57 yrs.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. HOURS 0	10. MIN 0	2c. DATE PRONOUNCED DEAD	MONTH Nov. 21, 1986	DAY 1986	YEAR 1986	2d HOUR 4:53 P.M.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington						
10. CITY OR TOWN OF DEATH Hagerstown												11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Under ground wire	12b. KIND OF BUSINESS OR INDUSTRY railroad
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1543 Kensington Drive		21740							
14. FATHER'S NAME FIRST Alonga			MIDDLE Vernon	LAST Trumpower	15. MOTHER'S MAIDEN NAME FIRST Fannie		MIDDLE Susan	LAST Hull						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 213-24-7595			17. INFORMANT ADDRESS Mrs. Dolly M. Trumpower		1543 Kensington Dr. Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure due to aortic stenosis, severe minutes DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Howard N. Weeks</i>		TITLE (SPECIFY) DEPUTY M.D. MEDICAL EXAMINER 580 Northern Avenue Hagerstown, Maryland 21740												
EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks, M.D.		DATE SIGNED 11/25/86												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 26, 1986			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Lawn			23d. LOCATION CITY OR TOWN Hagerstown			COUNTY Wash	STATE Maryland	
24. FUNERAL DIRECTOR NAME Minnich Funeral Home 415 E. Wilson Blvd.			25a. DATE REC'D. BY REGISTRAR DEC 01 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Scardon-Lindner</i>								
Hagerstown, Maryland														

0521386 105-9



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the certificates. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
<i>Elsie</i>			<i>E.</i>	<i>Vangieson</i>				<i>11-11-86</i>					<i>6:12 pm</i>		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<i>Female</i>			<i>Caucasian</i>			<i>10 05 1933</i>			<i>53</i>			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
<i>Alabama</i>			<i>United States</i>			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			<i>Washington County</i>						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Hagerstown</i>			<i>Washington County Hospital</i>						<i>Nurse</i>			<i>Hospital</i>			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			20877		
<i>Maryland</i>			<i>Montgomery</i>		<i>Gaithersburg</i>					<i>511 South Frederick Avenue, #13</i>					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
<i>Roy</i>			<i>William</i>	<i>Ellis</i>	<i>Elsie</i>				<i>Paige</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
<i>No</i>			<i>220-56-7445</i>			<i>Fran Lowe,</i>			<i>Route 1, Box 196-C</i>						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
						<i>Hepatic Failure - Coma</i>						<i>24 hours</i>			
						<i>Cirrhosis of Liver</i>						<i>10 years</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									<input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>11-2-86</i> , to <i>11-11-86</i> . That (II) (we) last saw the deceased alive on <i>11-11-86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>William W. Lesh MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>11-12-86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William W. Lesh, M. D.</i>			22e. ADDRESS <i>411 Division Avenue, Hagerstown, MD 21740</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>11-13-86</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>			23d. LOCATION CITY OR TOWN <i>Suitland, Maryland</i>			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME <i>Richard Rapp, Inc.</i>			ADDRESS <i>1804 T Street, NW, Washington, DC 20009</i>			25a. DATE RECEIVED BY REGISTRAR <i>NOV 17 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

[IMPORTANT] If item 21 is marked or if item 18 shows any injury, or other traumatic event, the State Dept. of Health and Mental Hygiene should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 3 3 2 1 9	
1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR								2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST Allen	MIDDLE P.	LAST Williams	11 02 86				10:17P		
3. SEX MALE		4 RACE Black		5. DATE OF BIRTH MONTH 09 DAY 30 YEAR 1915			6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County		MD.		
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Agriculture					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 350 Henry Street 21740			
14. FATHER'S NAME FIRST UNKNOWN		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME Alice		MIDDLE		LAST Williams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 229-09-8151		17. INFORMANT Theodore Parker		ADDRESS 111 Leeland Apts Martinsburg, WV 25401		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))				DOUE TO, OR AS A CONSEQUENCE OF <i>Cerebral edema</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.		(b) <i>Cerebral malignancy</i>									
(c)		DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Chronic Venous Disease, alcoholism</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>19 86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>R.L. Kugler MD</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <i>Geeting Lane, Keedysville, Md.</i>		22f. DATE SIGNED <u>11/3/86</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 6, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Cemetery		23d. LOCATION CITY OR TOWN Martinsburg		COUNTY	STATE Berkeley WV		
24. FUNERAL DIRECTOR <i>Charles M. Brown</i> Brown Funeral Home		327 W. King St. ADDRESS POBox 821, Martinsburg, WV		25a. DATE REC'D. BY REGISTRAR <u>NOV 10 1986</u>		25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Brown</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial permit. Then please remove carbon copy. Page 1 and 2 should be detached for use with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the deceased. The medical examiner may be notified of cause of death.

IMPORTANT: If Item 2 is marked or Item 18 shows any mobility, or other unusual condition, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 33220

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Bertha</i>	MIDDLE <i>Elizabeth</i>	LAST <i>WOLFE</i>	2a. DATE OF DEATH <i>November 4, 1986</i>	MONTH NOVEMBER	DAY 4	YEAR 1986	2b. HOUR M		
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH <i>February</i> DAY <i>17</i> YEAR <i>1911</i>			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i>			MD.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Potomac Towers</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY <i>mfg. co. & hosp.</i>						
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Potomac Towers 21740</i>					
14. FATHER'S NAME FIRST <i>Robert</i>		MIDDLE <i>Albertus</i>		LAST <i>Bailey</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Sarah</i>		MIDDLE <i>Thresa</i>		LAST <i>Finck</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>214-09-4453</i>		17. INFORMANT <i>Joanne Rodgers, Hagerstown, Md.</i>		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension, Atherosclerosis, Heart Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____													
DUE TO, OR AS A CONSEQUENCE OF _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10-20</i> , 19 <i>86</i> , to <i>11-4</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>10-20</i> , 19 <i>86</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE <i>Jacqueline L. Lee</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>11-5-86</i>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Nov. 7, 1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Hagerstown, Wash., Maryland</i>							
24. FUNERAL DIRECTOR <i>MINNICH FUNERAL HOME</i> NAME <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV - 7 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Minnich-Panday</i>									

028245 MA 1022

100% POLYESTER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, entombment or removal.

IMPORTANT: If item 21 is marked showing any injury, or any unusual event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Frederick Christian Wright, Jr.			11	17	1986	10:03 a.m.			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White	7	17	1914	72	YRS		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Washington County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Hagerstown		Washington County Hospital			Agent				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Maryland		Washington	Hagerstown		13e. STREET ADDRESS / ZIP CODE 112 S. Prospect St. 21740				
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST				
Frederick		Christian	Wright Sr.		Elvira	Middle	Virginia Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours		
Yes		WW II		220-18-1318 Helen H. Wright same as 13					
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Failure with Anoxia							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma from the thyroid						Months	
		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/7/76 to 11/17/86, that (I) (we) last saw the deceased alive on 11/17/86, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.								22c. DATE SIGNED 11/19/86	
22b. SIGNATURE 								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Howard N. Weeks, M.D. 580 Northern Ave., Hag. Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11-21-86	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown			STATE Wash. Md.
24. FUNERAL DIRECTOR NAME		ADDRESS 305 N. Potomac St. Gerald N. Minnich Hagerstown, Maryland			DATE REC'D. BY REGISTRAR DEO 01 1986			REGISTRATION NUMBER 305-1100	

Chittenden Co., Vt. 2000-10-30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or if item 18 shows any injury, or after traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 33264			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR / 15	
<i>Elmer Leo Kennedy</i>					<i>Wyand</i>	11 - 8 - 86					1 PM		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<i>Male</i>			<i>White</i>		MONTH	DAY	YEAR	82 YRS			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
<i>Maryland</i>			<i>USA</i>					<i>WASHINGTON</i>					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Hagerstown</i>			<i>Washington County Hospital</i>			<i>Supervisor</i>			<i>Leather</i>				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			MD.		
<i>Maryland</i>			<i>Washington</i>	<i>Williamsport</i>				<i>Rt. 3 Box# 35</i>			<i>21795</i>		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
<i>Benjamin Franklin Wyand</i>						FIRST	Catherine	MIDDLE	Elizabeth	LAST	Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no			215-09-7387			<i>Eleanor W. Miller</i>			<i>1720 W. Washington St.</i>			<i>Hagerstown, MD 21740</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Congestive Heart Failure</i>										1 week			
(c) <i>Atherosclerotic Heart Disease</i>										years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia <i>Hypertension, Chronic Obstructive Pulmonary Disease, Bronchitis</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <i>11-4-1986</i> to <i>11-8-1986</i> , that (I) <input type="checkbox"/> saw the deceased alive on <i>11-8-1986</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE <i>John A. Moran</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>11/10/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN A. MORAN MD.</i>			22e. ADDRESS <i>215 W Washington St., Hagerstown, Md</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Nov. 12, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Memoeial Pk			23d. LOCATION CITY OR TOWN Williamsport			COUNTY	MARYLAND
24. FUNERAL DIRECTOR NAME <i>Major M. Osborne</i>			ADDRESS <i>Williamsport, MD 21795</i>			25a. DATE REC'D. BY REGISTRAR <i>NOV 14 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Major M. Osborne</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit's permit. Then please give to embalmer. Pages 1 and 2 will be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR										363322		
I. DECEASED NAME (TYPE OR PRINT)			FIRST <u>PAUL</u>	MIDDLE <u>Ragan</u>	LAST <u>YOUNG, Jr.</u>	2a DATE OF DEATH <u>11/2/86</u>	MONTH <u>NOV</u>	2b HOUR <u>4:00 AM</u>				
3. SEX <u>male</u>			4 RACE <u>white</u>	5. DATE OF BIRTH MONTH <u>October</u> DAY <u>5</u> , YEAR <u>1926</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>60</u> YRS			IF UNDER 24 HRS <u>Minutes</u> <u>Hours</u> <u>Min.</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Hagerstown</u>			7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u>			
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Western Maryland Center</u>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY <u>State</u>			
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Washington</u>	13c. CITY OR TOWN <u>Hagerstown</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>Route 8, Box 238A</u>			21740	
14. FATHER'S NAME FIRST <u>Paul</u>			MIDDLE <u>R.</u>	LAST <u>Young, Sr.</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Esther</u>			MIDDLE	LAST <u>Benner</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>yes</u>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>W.W.II</u>			17 INFORMANT <u>Mrs. Evelyn Young, Hagerstown, Maryland</u>			ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Abcess, intraabdominal, left hip and thigh.</u>												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 21)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5/25/83</u> to <u>11/2/86</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11/2/86</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> view the body after death.												
22b. SIGNATURE <u>Rose Marie Chan, M.D.</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>11/2/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROSE MARIE CHAN, M.D.</u>			22e ADDRESS <u>Western Maryland Center, Hagerstown</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>			23b DATE <u>Nov. 2, 1986</u>	23c NAME OF CEMETERY OR CREMATORIAL <u>Smithsburg Crematory</u>			23d LOCATION CITY OR TOWN <u>Smithsburg, Wash., Maryland</u>			23e COUNTY <u>21740</u>		
24 FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u>			ADDRESS <u>415 East Wilson Blvd., Hagerstown, Maryland 21740</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 5 1986</u>			25b. REGISTRAR'S SIGNATURE <u>John Minnich</u>			

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